

Plaintiffs' Cross-Notice of Remote Deposition
and Non-Retained Expert Witness Disclosure of
Dr. Rahul Gupta

Exhibit 3

Gupta Deposition
April 15, 2021

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

* * * * *

THE CITY OF HUNTINGTON,

Plaintiff,

vs.

CIVIL ACTION
NO. 3:17-01362

AMERISOURCEBERGEN DRUG
CORPORATION, et al.,
Defendants.

CABELL COUNTY COMMISSION,
Plaintiff,

vs.

CIVIL ACTION
NO. 3:17-01665

AMERISOURCEBERGEN DRUG
CORPORATION, et al.,
Defendants.

* * * * *

Videotaped and videoconference deposition
of RAHUL GUPTA, M.D. taken by the Defendants under
the Federal Rules of Civil Procedure in the above-
entitled action, pursuant to notice, before Teresa
S. Evans, a Registered Merit Reporter, all parties
located remotely, on the 15th day of April, 2021.

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1 P R O C E E D I N G S

2 VIDEO OPERATOR: Good morning. We're
3 going on the record at 11:33 a.m. on April 15th,
4 2021. Please note that the microphones are
5 sensitive and may pick up whispering, private
6 conversations and cellular interference.

7 Please turn off all cell phones or
8 place them away from the microphones as they can
9 interfere with the deposition audio.

10 Audio and video recording will
11 continue to take place unless all parties agree to
12 go off the record.

13 This is Media Unit 1 of the video
14 recorded deposition of Rahul Gupta, M.D., taken by
15 Counsel for the Defendant in the matter of City of
16 Huntington versus AmerisourceBergen Drug
17 Corporation, et al and Cabell County Commission
18 versus AmerisourceBergen Drug Corporation, et al,
19 being filed in the United States District Court for
20 the Southern District of West Virginia, Case Nos.
21 3:17-01362 and 3:17-01665.

22 This deposition is being conducted
23 remotely via Zoom conferencing. My name is Adam
24 Hager from the firm Veritext; I'm the videographer.

1 The court reporter is Teresa Evans from the firm
2 Veritext.

3 I am not authorized to administer an
4 oath; I am not related to any party in this action;
5 nor am I financially interested in the outcome.

6 Counsel and all present in the room
7 and everyone attending remotely will now state
8 their appearances and affiliations for the record.

9 If there are any objections to
10 proceeding, please state them at the time of your
11 appearance, beginning with the noticing attorney.

12 MS. MAINIGI: Good afternoon. This is
13 Enu Mainigi from Williams & Connolly for Cardinal
14 Health.

15 MR. RUBY: And Steve Ruby also for
16 Cardinal Health.

17 MR. HESTER: This is Timothy Hester
18 from Covington & Burling representing McKesson
19 Corporation.

20 MS. CALLAS: Gretchen --

21 MR. BAILEY: This is -- sorry.
22 Clayton Bailey also from Covington & Burling, for
23 McKesson.

24 MS. CALLAS: Gretchen Callas for

1 AmerisourceBergen.

2 MS. KEARSE: Anne Kearse on behalf of
3 the Plaintiffs.

4 MR. MAJESTRO: Anthony Majestro on
5 behalf of the Plaintiffs.

6 MR. FARRELL: Paul Farrell on behalf
7 of the plaintiffs.

8 MR. COLANTONIO: Mark Colantonio, Bob
9 Fitzsimmons, representing Doctor Gupta for purposes
10 of this deposition.

11 MR. SHKOLNIK: Hunter Shkolnik also
12 representing Doctor Gupta for the purposes of this
13 deposition.

14 VIDEO OPERATOR: If there are no
15 further appearances to be noted, would the court
16 reporter please swear the witness.

17 (The witness was sworn.)

18 R A H U L G U P T A , M. D. ,
19 was called as a witness by the Defendants, and
20 having been first duly sworn, testified as follows:

21 EXAMINATION

22 BY MS. MAINIGI:

23 Q. Good afternoon, or good morning, Doctor
24 Gupta. How are you today?

1 A. Good morning. I am well, thank you. And
2 how are you?

3 Q. I'm good, thank you. We met off the
4 record, but just I'll state it again. My name is
5 Enu Mainigi, and I represent Cardinal Health, and
6 I'm going to be doing the questioning today.

7 Before we get started, Doctor Gupta,
8 you are -- where are you doing this deposition
9 from?

10 A. I'm doing this deposition from Pentagon
11 City.

12 Q. And at a particular office? Whose office?

13 A. This is the Ritz Carlton at Pentagon City.

14 Q. And who is in the room with you, Doctor
15 Gupta?

16 A. Mark Colantonio and Bob Fitzsimmons.

17 Q. And those are the only individuals in the
18 room with you?

19 A. Yes.

20 Q. And besides the exhibits that your
21 attorneys may have received from us to have handy
22 for you, do you have any other documents in front
23 of you?

24 A. No.

1 Q. Do you have any notes in front of you?

2 A. No.

3 Q. Doctor Gupta, you were deposed in this case
4 last September. Do you understand why we are here
5 doing another deposition?

6 A. I do have a fair amount of understanding.

7 Q. Could you explain to me what your
8 understanding is?

9 A. My understanding is that you want to talk
10 to me to see if there's another -- more areas
11 within the context of the previous deposition that
12 I can help with.

13 Q. Are your -- are you aware, Doctor Gupta,
14 that counsel for Cabell and Huntington submitted a
15 supplementary disclosure regarding potential expert
16 opinions that you might offer at trial?

17 A. I'm not aware.

18 Q. Could you put --

19 MS. MAINIGI: Bob, are you going to be
20 the one assisting with exhibits?

21 MR. COLANTONIO: Well, we don't have
22 -- we didn't print out the actual exhibits here. I
23 have them on e-mail, but we don't -- so I just kind
24 of prefer -- this is Mark speaking, by the way.

1 You put them up on the -- for the doctor to see and
2 then he can comment on them.

3 But we don't have printouts right here
4 of all the exhibits.

5 MS. MAINIGI: Okay. Steve, are you --

6 MR. RUBY: I thought -- sorry, Mark, I
7 thought you guys were going to have them printed
8 for -- for doctor Gupta.

9 MR. COLANTONIO: Yeah, I apologize if
10 that was a -- I didn't -- I just don't have them
11 here, Steve. But I think -- I think if you put
12 them up that he'll be able to, you know, do it that
13 way.

14 MR. RUBY: Well, let's do this. Let
15 me --

16 MS. KEARSE: Yeah, Steve, I thought
17 you were doing them remotely as well. We just --
18 and we didn't get copies of them.

19 MR. RUBY: Hold on. Let me --

20 MS. MAINIGI: Well, while -- while we
21 gather up some of the exhibits, I think, Steve,
22 we'd want to -- I'm not even sure we need 51, but I
23 guess 58 would be one of the next ones.

24 BY MS. MAINIGI:

1 Q. So Doctor Gupta, let's just go ahead and
2 jump in. Is it correct that you worked in West
3 Virginia from approximately 2009 to 2017?

4 A. That is correct, but that is not the
5 entirety of my experience in West Virginia.

6 Q. What other experience did you have in West
7 Virginia beyond -- beyond the experience of those
8 years?

9 A. I had worked in West Virginia from March of
10 2009 to November of 2018. And after that, I
11 continued to be a volunteer physician to date with
12 West Virginia Health Right, which is a charitable
13 clinic in Charleston, West Virginia.

14 Q. And is that something you do through today,
15 Doctor Gupta?

16 A. Yes.

17 Q. And how often do you volunteer as a
18 physician at that clinic?

19 A. I would take advantage of every time I'm
20 able to or most times I'm able to visit West
21 Virginia, to be able to do that. That could be
22 ranging anywhere from once a month to once every
23 few months.

24 Q. And that has happened since your departure

1 from West Virginia in approximately November of
2 2018. Is that correct?

3 A. I have volunteered in my time since my
4 departure from West Virginia in November of 2018.

5 Q. And your present position, Doctor Gupta, is
6 being the chief medical officer at the March of
7 Dimes; is that correct?

8 A. My current position at March of Dimes is
9 chief medical and health officer, as well as the
10 interim chief science officer, and senior vice
11 president --

12 Q. I'm sorry, you cut out there, Doctor.
13 Senior vice president of what?

14 A. Of March of Dimes.

15 Q. Did you take the role at the March of Dimes
16 beginning in approximately 2018?

17 A. Yes.

18 Q. And you moved to the Washington, D.C. area
19 around that time?

20 A. I did not move immediately to the
21 Washington area.

22 Q. Did you commute for some period of time?

23 A. Yes.

24 Q. When did you move to the Washington, D.C.

1 area?

2 A. Probably around February or March of 2019.

3 Q. Doctor Gupta, the March of Dimes is a
4 global organization focused on maternal and infant
5 health; is that correct?

6 A. Yes.

7 Q. And the March of Dimes works on prenatal
8 education, among other things. Is that correct?

9 A. That would be part of the work that we do
10 at March of Dimes.

11 Q. And also professional education?

12 A. That would be accurate as well.

13 Q. And also NICU support and resources?

14 A. That would also be accurate, NICU standing
15 for neonatal ICU.

16 Q. Thank you. And also health equity, Doctor
17 Gupta?

18 A. That would also be correct.

19 Q. And a fairly extensive medical research
20 agenda? Is that correct also?

21 A. That would be correct.

22 Q. And the work that the March of Dimes does,
23 that's done on a global basis, true?

24 A. The work of March of Dimes historically and

1 currently is done both at domestic levels as well
2 as international level.

3 Q. Now, while at the March of Dimes, Doctor
4 Gupta, you are not acting as a specialist in
5 addiction treatment, correct?

6 A. That would be correct.

7 Q. You're not acting as a specialist in pain
8 management, correct?

9 A. That would be correct.

10 Q. You're not a specialist in neurobiology,
11 correct?

12 A. Could you please repeat that last one?

13 Q. Sure. You are not acting as a specialist
14 in neuro -- neurobiology, correct?

15 A. Could you please explain? I'm not -- no, I
16 mean, I don't understand the question about a
17 specialist in neurobiology. There's no - to my
18 knowledge - a physician position of being a
19 specialist in neurobiology.

20 Q. Okay. Thank you. And you're not acting as
21 a specialist at the March of Dimes in epidemiology,
22 correct?

23 A. That would be incorrect.

24 Q. That would be incorrect?

1 A. That's correct.

2 Q. Okay. Could you explain to me how you are
3 -- what your role is as a specialist in
4 epidemiology at the March of Dimes?

5 A. My work that includes the title of the
6 chief medical and health officer as well as the
7 chief science officer often involves the engagement
8 of the principles of epidemiology, biostatistics,
9 policy, which are all part of my training as well
10 as my experience and expertise.

11 Q. Do you act as a specialist in epidemiology
12 in -- at the March of Dimes, Doctor Gupta? Or do
13 you interact with epidemiologists?

14 A. I am the person that is in charge and not
15 only in charge of other epidemiologists, but I am
16 the person that other epidemiologists look to for
17 expert advice.

18 Q. And do other epidemiologists look to you
19 for epidemiology advice?

20 A. That's correct.

21 Q. In what areas, please?

22 A. In areas of epidemiology.

23 Q. And can you give me specific areas, please?

24 A. Areas of maternal health, infant health,

1 population health, health policy, biostatistics. I
2 can go on.

3 Q. Do you have any training in epidemiology,
4 Doctor Gupta?

5 A. I have both training and experience.

6 Q. Do you have -- let me ask this first: Do
7 you have any formal training in epidemiology?

8 A. Yes.

9 Q. What is the formal training you have in
10 epidemiology?

11 A. Beyond my medical degree where I had
12 extensive training in public health and
13 epidemiological practices of five and a half years,
14 I have a master's in public health from University
15 of Alabama-Birmingham.

16 Q. Have you ever held yourself out as an
17 epidemiologist when you were practicing medicine,
18 Doctor Gupta?

19 A. I do not understand the nature of the
20 question. Could you please rephrase?

21 Q. Sure. You have a -- you have training in
22 internal medicine, correct?

23 A. Correct.

24 Q. And I -- as I understand it, for some

1 period of time, you were in private practice and
2 you held yourself out as an internist. Correct?

3 A. Amongst other areas as well, correct.

4 Q. And my question to you then, with that
5 background, is: Have you ever held yourself out as
6 an epidemiologist and solely an epidemiologist?

7 A. I still do not understand the nature of the
8 question of being a physician solely as an
9 epidemiologist. I can help to answer the question
10 this way: That as the local health officer and
11 physician director, which is the official position
12 at Kanawha-Charleston Health Department, my role
13 from March of 2009 to December of 2014 - which was
14 almost six years - involved leading a team of
15 epidemiologists in a variety of work that included
16 conducting epidemiological surveys, studies,
17 analysis and policy making as a result of that work
18 for the largest county in the state of West
19 Virginia, which is Kanawha County.

20 Following that, because partly of that
21 work, the Governor of the state of West Virginia
22 asked me to serve as the State Health Officer,
23 which also requires to have - similar to
24 Kanawha-Charleston Health Department - a

1 significant experience and expertise in
2 epidemiology in order to serve in that position.

3 So both of those positions, from March
4 of 2009 to November of 2018, required significant
5 expertise in epidemiology as -- as per stated in
6 statute for the State of West Virginia and the
7 policies of Kanawha Charleston Health Department.

8 Q. Okay. We'll come back to that time period.

9 MR. RUBY: Enu, not to interrupt, but
10 we are set up to screen share the exhibits whenever
11 you want.

12 MS. MAINIGI: Oh, terrific.

13 Q. Speaking of West Virginia, when you were in
14 West Virginia, did you ever live in Huntington?

15 A. No.

16 Q. Did you ever live in Cabell County?

17 A. No.

18 Q. Did you ever work in Huntington?

19 A. Yes.

20 Q. And when -- from when to when did you work
21 in Huntington?

22 A. My work as the health commissioner for the
23 State and the State Health Officer required me to
24 ensure that my work involved not just in Kanawha

1 County, but for all 55 counties and all the cities
2 within the jurisdiction of the State of West
3 Virginia.

4 That work involved a number of
5 activities, including visits, as well as
6 epidemiological work, investigatory work,
7 regulatory work, as well as other facets that
8 included Cabell County as well as the City of
9 Huntington.

10 And part of my job was to not only
11 work with the public health department, but also
12 the elected and other officials from Cabell County
13 and the City of Huntington.

14 Q. How often do you think while you were in
15 that role, Doctor Gupta, that you visited
16 Huntington or Cabell County?

17 A. Could you please define the time period?

18 Q. The time period that you were State
19 commissioner.

20 A. I would visit the City of Huntington and
21 Cabell County, broadly speaking, anywhere from, you
22 know, once every couple of weeks to once every
23 couple of months.

24 Q. Were -- was there a system at the

1 Commission of keeping track of where you traveled?

2 Was there a log or something that was maintained?

3 A. I'm sorry, which commission?

4 Q. Well, let's see. You became the State --
5 you're speaking about the State health commission,
6 correct? In that role as the State Health Officer,
7 you visited Cabell and Huntington. Right?

8 A. No, Ms. Mainigi, I was the Commissioner of
9 the Bureau of Public Health at the West Virginia
10 Department of Health and Human Resources, which is
11 -- also provides the -- by statute, the position of
12 the State Health Officer, so I'll just step back a
13 little bit and help to -- help --

14 Q. That's okay. I -- not to interrupt you,
15 but thank you for that clarification. So let me
16 just keep going. While you were the Commissioner
17 of public health, that's when you made somewhat
18 periodic visits to Cabell and Huntington, correct?

19 A. That is not the only time.

20 Q. Okay. Well, let's stick with the time you
21 were in that role. You mentioned that you ranged
22 from one time every couple of weeks to one time
23 every couple of months, correct?

24 A. Yes.

1 Q. And my question to you, sir, is: Is there
2 a log that was maintained of the various places you
3 visited, including Cabell and Huntington?

4 A. There were a lot of visits. I think you
5 would have to ask the Department of Health and
6 Human Resources about the policies of keeping those
7 type logs. I would not be the right person for
8 that.

9 Q. And then you wanted to tell me about
10 another time, or in another job that you visited
11 Cabell and Huntington, right? What role was that
12 that you helped?

13 A. Sure. That was the role of being the
14 physician director and local health officer for the
15 largest county in the state of West Virginia, and
16 one of the largest other counties was Cabell County
17 and the City of Huntington.

18 So what that meant was it was critical
19 that we -- the two health officers were the only
20 two full-time health officers that were local
21 health officers in the State of West Virginia, so
22 it was essential for us to have a very close
23 relationship and understand what is happening in
24 each of our counties.

1 That required a lot of traveling back
2 and forth, both for the local health officer of
3 Cabell-Huntington Health Department as well as that
4 of Kanawha-Charleston Health Department.

5 Q. Okay. So just to clarify, you were the
6 executive director of the Kanawha-Charleston Health
7 Department, correct?

8 A. Executive director and physician health
9 officer.

10 Q. Okay. And there was someone else that was
11 in the role of the Cabell-Huntington Health
12 Department head, correct?

13 A. Right.

14 Q. And who was that person?

15 A. Currently, it's --

16 Q. Well, let me interrupt you. While you were
17 -- and I apologize for that.

18 MS. KEARSE: I guess, Enu, if he's --
19 let him finish answering your question --

20 MS. MAINIGI: Okay. I don't think he
21 was actually --

22 Q. My question was unclear, actually, Doctor
23 Gupta. Let me clarify, if you don't mind, my
24 question.

1 At the time you were head of
2 Kanawha-Charleston, who was, to your recollection,
3 the head of Cabell?

4 A. The current health officer, Doctor Michael
5 Kilkenny, and the prior health officer, prior --
6 the predecessor of Doctor Kilkenny, those were the
7 two health officers I primarily dealt with.

8 Q. Thank you.

9 A. And it may have been that -- I don't
10 remember exactly when Doctor Kilkenny was hired, so
11 I -- you know, it's been a while, so excuse me for
12 not remembering exact dates.

13 Q. No problem, Doctor Gupta. Now, Dr. Gupta,
14 as I understand it, you right now are under
15 consider -- under consideration to be drug czar of
16 the United States?

17 A. Is there a question there?

18 Q. Yes. That's the question. Are you under
19 consideration to be drug czar?

20 A. Well, I think the reports in the media that
21 have reached out to me and others, I have -- I will
22 provide you the same answer as I have to them,
23 which is I don't have anything to say about that
24 right now.

1 Q. Are you currently being vetted for that
2 position?

3 A. I don't have anything to say about matters
4 that do not pertain to this particular deposition.

5 Q. Well, Doctor Gupta, with all due respect to
6 you, I do think you've got to answer the question.
7 Let me work a little bit backwards and maybe you'll
8 understand --

9 MS. KEARSE: And Enu, I understand --

10 MS. MAINIGI: Hang on. Let me finish,
11 and you can object to the next question if you want
12 to, but Anne, I don't need any speaking objections.

13 MS. KEARSE: I didn't even get to say
14 anything, Enu.

15 BY MS. MAINIGI:

16 Q. Doctor Gupta, are you intending to testify
17 at the trial in this matter?

18 A. Yes.

19 Q. And are you expecting to testify in person
20 at the trial in this matter?

21 A. Yes.

22 Q. How does the timing -- to your knowledge,
23 how does the timing of your possible nomination to
24 this role of drug czar relate to your testimony in

1 this matter, with this matter beginning trial on
2 May 3rd?

3 MR. COLANTONIO: You're asking him as
4 to his physical appearance at trial, right?

5 MS. MAINIGI: Correct.

6 A. Ms. Mainigi, you are speculating at this
7 point and which I prefer not to answer and not to
8 give -- not to speculate answers for.

9 Q. Okay. That did not, Doctor Gupta, answer
10 my question. If you were -- let me ask it this way
11 and perhaps that will help you.

12 MR. COLANTONIO: Enu, can I help?

13 MS. MAINIGI: No. No, thank you.

14 MR. COLANTONIO: All right.

15 Q. If you are nominated to be drug czar, will
16 you testify still at the trial in this matter that
17 begins on May 3rd?

18 MS. KEARSE: Objection, calls for
19 speculation.

20 A. Ms. Mainigi, I just cannot -- sitting here
21 today, I'm trying to help to determine the facts of
22 the -- of your questioning and the line of
23 questioning. The judge has asked me to do that,
24 and I'm happy to do that. But I can't answer any

1 speculative questions at this point.

2 Q. Doctor Gupta, if you are confirmed as drug
3 czar, will you testify in this matter?

4 MS. KEARSE: Objection.

5 A. My answers remain the same.

6 Q. Doctor Gupta, what is the current status of
7 your application to be drug czar?

8 MS. KEARSE: Objection.

9 A. My answers are already said. Asked and
10 answered.

11 MS. KEARSE: And Enu, this is Anne
12 Kearse again. This is a targeted -- this is a
13 targeted deposition that the judge ordered, so I
14 think we should stick to the order and proceed with
15 the questions that -- outside of this area of
16 testimony.

17 MS. MAINIGI: Thank you, Anne, but I'm
18 sure Doctor Gupta can answer these questions for
19 himself.

20 Q. Doctor Gupta, you did not answer -- you did
21 not answer my question.

22 MS. MAINIGI: Could I have my question
23 read back, please?

24 COURT REPORTER: Sure.

1 (The question was read by the court
2 reporter.)

3 A. Doctor Gupta, please answer that question.

4 MS. KEARSE: Objection. And I have a
5 standing objection to this line of questioning.

6 A. I don't know.

7 Q. You mentioned that the judge had asked for
8 your help in this matter. What is your
9 understanding of the help that the judge has asked
10 for?

11 A. As I stated prior, I'll repeat my answer
12 again, which is that my understanding of this
13 deposition is that you would like to know more into
14 the depth of my prior deposition, which I'm happy
15 to be here voluntarily and provide that information
16 to you.

17 Q. You were deposed in September, correct,
18 Doctor Gupta?

19 A. To my recollection, yes.

20 Q. At that time, had -- to your recollection,
21 had your name been suggested by anyone that you're
22 aware of for the role of drug czar?

23 A. I don't know.

24 Q. Just circling back a little bit on your

1 background -- further on your background, Doctor --
2 Doctor Gupta, you have a one-year undergraduate
3 degree and a medical degree from the University of
4 Delhi, correct?

5 A. Not correct.

6 Q. What is not correct about that?

7 A. I don't have a one-year degree,
8 undergraduate degree.

9 Q. You have an undergraduate degree from the
10 University of Delhi, correct?

11 A. Incorrect.

12 Q. Okay. What is the -- what are the degrees
13 you have from the University of Delhi?

14 A. I have master's of -- excuse me.
15 Bachelor's of medicine and bachelor's of surgery
16 degree. I have diploma in tuberculosis and chest
17 diseases.

18 Q. You have an undergraduate degree from the
19 University of Delhi.

20 A. Is that a question?

21 Q. Yes.

22 A. I have -- I do not have a degree, one-year
23 degree, from the University of Delhi.

24 Q. Do you have an undergraduate degree from

1 the University of Delhi?

2 A. I do not have an undergraduate degree from
3 the University of Delhi.

4 Q. Okay. And I think you referred to this
5 already, but after your medical degree, did you --
6 you received specialized training in tuberculosis
7 and chest diseases? Is that correct?

8 A. That's correct.

9 Q. And then you received a master's -- do you
10 have a -- let me just come back to your
11 undergraduate degree. Do you have a bachelor of
12 science from the University of Delhi?

13 A. I do not.

14 Q. You do not have a bachelor of science
15 degree from the University of Delhi.

16 A. I do not have a bachelor of science degree
17 from the University of Delhi.

18 Q. So if we -- if you testified to that
19 previously, was that incorrect?

20 A. I would have to look at my testimony
21 previously to determine that.

22 Q. Okay. You have a master's in public health
23 from the University of Alabama at Birmingham?

24 A. That's correct.

1 Q. And then you have an M.B.A. that you
2 obtained through UNINETTUNO University; is that
3 correct?

4 A. I'm sorry, could you repeat that?

5 Q. Do you have an M.B.A.?

6 A. Yes.

7 Q. And where is that from?

8 A. That's the London School of Business and
9 Finance.

10 Q. And what degree, if any, do you have from
11 UNINETTUNO University?

12 A. I think it's the same one. They -- there's
13 -- it's the London School of Business And Finance.
14 This is the other name for that, or that's one of
15 the issuing degrees; the other is where you go to
16 school. That's -- I think that's the confusion you
17 may--

18 Q. Did you go to school in London or was it an
19 online program?

20 A. Mostly online program.

21 Q. And was that online program based in Italy?

22 A. There were some optional classes to be able
23 to attend in Italy as well as in London.

24 Q. Now, you were in private medical practice

1 for four years in Alabama; is that right?

2 A. If you -- it would be helpful if you gave
3 me the years so I can -- because there were several
4 others in that time as well.

5 Q. I was hoping you'd have your CV printed
6 out, but that's not the case. So I don't know the
7 years off the top of my head, but did you
8 practice --

9 Let me go ahead and pull up your CV.

10 MR. RUBY: Enu, I can put this on the
11 screen share if it's helpful.

12 MS. MAINIGI: That would be terrific.

13 Q. I don't think it's a controversial fact
14 here, Doctor Gupta, but --

15 MR. RUBY: And just --

16 Q. -- your CV reflected you were in private
17 medical practice for four years?

18 MR. RUBY: Just administratively, I'll
19 note that this was Exhibit 51 from the September
20 2020 deposition of Doctor Gupta in this case.

21 A. So if you're referring, Ms. Mainigi, to
22 primary care physician, Florala Medical Clinic,
23 2000 to 2004, that's accurate.

24 Q. Okay, thank you. And as a primary care

1 physician, you dealt with whatever problems walked
2 in the door. Correct?

3 A. I had a clinical practice, outpatient
4 practice. I also functioned as an emergency room
5 physician for the local hospital, and in that
6 sense, for both of those positions, I did have to
7 deal with, in a rural underserved area, to a
8 variety of patients and a variety of needs.

9 Q. And then you became -- after that point,
10 Doctor Gupta, you became a practicing faculty
11 member at the University of Alabama-Birmingham; is
12 that right?

13 A. That's correct.

14 Q. And there you also specialized in internal
15 medicine, correct?

16 A. I specialized in internal medicine, primary
17 care, as well as hospitalist.

18 Q. And it was after that time period that you
19 became the executive director of the
20 Kanawha-Charleston Health Department in West
21 Virginia; is that correct?

22 A. I think you skipped the -- my tenure in
23 Nashville. But at some point, it is correct that
24 after that, technically, I became -- I moved to

1 West Virginia, but not before taking a route
2 through Nashville.

3 Q. Ah, I'm sorry about that. Thank you for
4 adding that in. In Nashville, you also specialized
5 in internal medicine; is that right?

6 A. I was internist. I was also a hospitalist.
7 I was also a primary care physician and an academic
8 physician both at Meharry Medical College and
9 Vanderbilt University Medical School in Nashville,
10 both in Tennessee.

11 Q. And then when you became the executive
12 director of the Kanawha-Charleston Health
13 Department, that was in approximately 2009? Is
14 that correct?

15 A. That is correct.

16 Q. And the role that you held there as
17 executive director of the Kanawha-Charleston Health
18 Department, that role covered a wide range of
19 duties; is that right?

20 A. That would be right, accurate.

21 Q. And so just -- I want to just run through
22 the areas of coverage, if I could, Doctor Gupta.
23 As I understand it from some of the materials we've
24 read, some of the areas of coverage for that role

1 included diabetes, for example? Is that right?

2 A. That would be correct.

3 Q. Obesity, correct?

4 A. That would be correct.

5 Q. Heart disease?

6 A. Correct.

7 Q. I think you also set up a school or helped
8 to set up a School of Public Health at West
9 Virginia University while in role, correct?

10 A. That would be correct.

11 Q. And you ran a program to respond to the
12 three chronic health problems of obesity, diabetes
13 and heart disease, correct?

14 A. Amongst other things, yes, that is correct.

15 Q. And you set up the State minority affairs
16 office, correct?

17 A. I helped in the legislation passage for the
18 Governor's cabinet office of minority affairs.

19 Q. And did you help to set up a pulmonary
20 rehab project while executive director?

21 A. I supported the setup of that as well.

22 Q. Did you also work on Medicaid expansion
23 under ACA while executive director?

24 A. I successfully helped persuade then-

1 Governor Tomblin to expand Medicaid as part of the
2 Affordable Care Act in West Virginia.

3 Q. You also, while executive director,
4 responded to a major water contamination event,
5 correct?

6 A. Right.

7 Q. And your agency was responsible for
8 inspecting restaurants, correct?

9 A. Correct. In -- within the confines of the
10 jurisdiction of Kanawha County, including the City
11 of Charleston.

12 Q. And your agency was also responsible for
13 indoor air quality, correct?

14 A. Correct.

15 Q. Also responsible for immunizations,
16 correct?

17 A. That would be accurate.

18 Q. Also responsible for tuberculosis, correct?

19 A. Responsible for surveillance of
20 tuberculosis, case management, case investigation
21 as well as provide -- helping ensuring treatment
22 for those cases which were made, as well as the
23 work.

24 Q. In your role as executive director, your

1 agency was also responsible for lice treatment and
2 counseling, correct?

3 A. The department would be responsible for
4 ensuring all the public health activities and the
5 confines of which included ensuring safe schools,
6 which often also included, amongst other things,
7 making sure that there was enough of treatments
8 available for lice.

9 Q. And on top of those responsibilities, you
10 also had responsibility for day-to-day management
11 of the health department, correct?

12 A. That would be correct.

13 Q. And probably some other areas that we
14 haven't discussed. Correct?

15 A. That would be accurate.

16 Q. Now, while you were at -- while you were
17 executive director of Kanawha-Charleston, the
18 Health Department, did you act as a specialist in
19 addiction treatment?

20 A. No.

21 Q. Did you act as a specialist in pain
22 management?

23 A. No.

24 Q. Did you act as a specialist in

1 neurobiology?

2 A. Once again, I'm not aware of particular
3 licensing around neurobiology physicians.

4 Q. And once again, you would say, Doctor
5 Gupta, that you did act as a specialist in
6 epidemiology while you were executive director; is
7 that right?

8 A. That would be accurate.

9 Q. And do you have any licensing in
10 epidemiology?

11 A. I'm -- I'm not sure -- which particular
12 licensing are you asking about?

13 Q. Well, to your knowledge, is there licensing
14 that exists for epidemiology?

15 A. I am not aware of a physician specialty
16 through the Board of Medicine that is exclusive for
17 epidemiologists' practice.

18 Q. So you're not aware of any licensing
19 related to epidemiology.

20 A. I'm not aware of any specialist licensing
21 in the medical practice of West Virginia that
22 provides that type of licensing.

23 Q. Okay. And what about outside of West
24 Virginia? Are you aware of any medical

1 organizations that license in epidemiology?

2 A. I would not be aware at this time of any
3 particular organizations. Knowing that the
4 practice of medicine is regulated by State Board of
5 Medicine, not outside organizations, in the State
6 of West Virginia.

7 Q. Now, in 2014, you became the State Health
8 Officer for West Virginia, correct?

9 A. I'm sorry, could you repeat that, please?

10 Q. In 2014, you assumed the role of the State
11 Health Officer for West Virginia?

12 A. That would be incorrect.

13 Q. Tell me how it's incorrect.

14 A. I assumed the role in January of 2015 of
15 commissioner for the Bureau of Public Health at
16 DHHR and the State Health Officer.

17 Q. Let me just go back to the epidemiology
18 point. Are you aware of an organization called the
19 American College of Epidemiology?

20 A. Not -- that doesn't sound like an
21 organization that I have worked with.

22 Q. So if you haven't heard of it, you're not a
23 member of it, I assume.

24 A. I don't think I'm a member of it.

1 Q. Now, your role that you assumed in January
2 of 2015 as the State Health Officer for West
3 Virginia, I assume that had a wider range of duties
4 than the duties you had at Kanawha Charleston,
5 correct?

6 A. That would be accurate.

7 Q. And so as the State Health Officer, as I
8 understand it, you oversaw more than 130 separate
9 programs; is that right?

10 A. That would be accurate, and just wanted to
11 add so -- in case -- I know you probably didn't
12 mean to miss this out on purpose, but during that
13 time, I was also the health officer and physician
14 director for Putnam County Health Department as
15 well, part of the time that I was in Kanawha
16 County.

17 That's -- and by the way, just to --
18 for your knowledge, that's the connection county
19 between Cabell and Kanawha. You have to drive
20 through Putnam County to get to Cabell.

21 So during that time also - going back
22 to your previous question - I was in the most
23 contiguous county next to Cabell and the City of
24 Huntington, and that was another level of

1 importance that we had to coordinate our work with
2 Cabell County.

3 So these three contiguous counties
4 linked with each other, and it was critical that we
5 worked together.

6 Q. Thank you. Coming back to your role as
7 State Health Officer, Doctor Gupta, you had a
8 budget of about \$270,000,000; is that right?

9 A. That was my direct responsibility. I also
10 had some indirect responsibilities as well.

11 Q. But your budget, your direct responsibility
12 budget, was about \$270,000,000?

13 A. That would be accurate.

14 Q. Okay. And you had about 500 plus
15 employees, correct?

16 A. That would be correct.

17 Q. And you oversaw the State's EMS system; is
18 that correct?

19 A. That is also.

20 Q. And in terms of areas that you worked on,
21 do some of the areas include - let me go through a
22 list with you like we did before - community
23 paramedicine? Accurate?

24 A. Yes. That was one particular program that

1 I was the architect of.

2 Q. Okay. Environmental health? Is that
3 accurately a duty of yours?

4 A. I oversaw the Office of Environmental
5 Health Services.

6 Q. And again, immunizations? Did you oversee
7 immunizations?

8 A. I did oversee the Office of Immunization
9 Services.

10 Q. Did you oversee any sort of program related
11 to the health effects of surface coal mining?

12 A. I don't remember if there was any program
13 that you mentioned.

14 Q. Did you oversee flood response?

15 A. I'm sorry, could you repeat that?

16 Q. Yes. Did you oversee flood response?

17 A. As the State Health Commissioner, there
18 were portions of the flood response that we oversaw
19 working very closely with the other first
20 responders at state and local levels.

21 Q. How about the Office of Laboratory
22 Services? Did you oversee that office?

23 A. Yes.

24 Q. Did you oversee bioterrorism preparedness?

1 A. Yes.

2 Q. Did you oversee any Zika outbreaks?

3 A. I did oversee the planning for Zika as well
4 as the action plan and other activities related to
5 the -- to the Zika outbreak.

6 Q. And I assume you had to develop a plan, a
7 Strategic Plan, for the whole Department of Health
8 and Human Resources while you were the State Health
9 Officer?

10 A. Yes, I assisted in that as well.

11 Q. Were you also the secretary of the West
12 Virginia Board of Medicine?

13 A. Yes.

14 Q. And were you involved in medical licensing
15 and discipline?

16 A. Yes.

17 Q. And did you have day-to-day management for
18 the Bureau of Public Health?

19 A. Could you repeat that, please?

20 Q. Sure. Did you have day-to-day management
21 of the Bureau for Public Health?

22 A. Yes.

23 Q. And I assume there are other areas that
24 weren't specifically highlighted in your resume

1 that you covered as the State Health Officer. Is
2 that fair?

3 A. Yeah, along with these areas that you
4 mentioned, all of which required epidemiological
5 expertise. There are some other areas as well that
6 required epidemiological expertise in leadership,
7 yes.

8 Q. Now, you had mentioned earlier your work --
9 well, actually, let me start over. While you were
10 the State Health Officer, did you also work time as
11 a practicing physician in a volunteer capacity?

12 A. While I was the State Health Officer, I
13 took personal time off to volunteer in my community
14 on a personal level at the charity clinic West
15 Virginia Health Right, and have been doing that
16 since 2009.

17 Q. It's the same clinic that you've been
18 volunteering at since 2009?

19 A. Yes.

20 Q. And you volunteer at that clinic as a
21 general practitioner; is that right?

22 A. Primary care practitioner, an internist.

23 Q. Now, Doctor Gupta, you've been retained as
24 an expert consultant in opioid litigation in West

1 Virginia, correct?

2 A. I am not sure which -- there's multiple --
3 so if you could help me understand which particular
4 litigation you're --

5 Q. Sure. You -- the counsel that you're
6 sitting with, as well as Mr. Shkolnik who's on
7 video, you've been retained by them as an expert
8 consultant in opioid litigation in West Virginia,
9 correct?

10 A. Yes.

11 Q. And that's a different set of cases than
12 the case that you're testifying in here today,
13 correct? Do you understand that?

14 A. I don't -- I don't know exactly, but -- I
15 don't know exactly what the set of those cases
16 versus these cases are. I understand that -- that
17 I'm here testifying as a result of being asked to
18 testify.

19 Q. And the work that you're doing as an
20 expert, you're paid for that work, correct?

21 A. Which is not this case. The other case,
22 yes.

23 Q. Okay. So you do understand you're not a
24 paid expert in this case, correct?

1 A. Correct.

2 Q. Okay. The other case where you are a paid
3 expert, what's the rate at which you're paid?

4 A. I actually don't remember. I will be happy
5 to get that to you.

6 Q. Okay. Does \$500.00 an hour, does that ring
7 a bell?

8 A. That would be somewhere close to it, the
9 range.

10 Q. And is that engagement still in effect
11 today? Meaning you're a paid expert consultant in
12 that other case?

13 A. Yes.

14 Q. And that paid engagement was in effect, I
15 think, in September 2020 when you last testified,
16 correct?

17 A. Correct.

18 Q. Now, do you remember giving an opioid -- a
19 deposition in an opioid case back in about 2016?

20 A. I do remember, yes.

21 Q. And you were not a paid expert consultant
22 in 2016, correct?

23 A. Correct.

24 Q. Do you remember approximately what time

1 period you became a paid expert consultant?

2 A. At this point, I can only guess as
3 somewhere in 2019.

4 Q. And when you were first approached to be a
5 paid expert consultant, was it on the topic of
6 abatement?

7 A. Yes.

8 Q. Since that time, has your work expanded to
9 cover other areas besides abatement?

10 A. No.

11 Q. So you remain a paid expert consultant in
12 the area of abatement; is that right?

13 A. Yes.

14 Q. And how do you define "abatement"?

15 A. Abatement is all those strategies that
16 would help to address the problem that we're facing
17 today.

18 Q. So give me some examples.

19 A. Examples would be to figure out how to
20 treat -- have a system of treatment, system of
21 response, a system of where people can be addressed
22 with their first nonfatal overdose so they don't
23 die eventually. We could put in measures that
24 could prevent the spread of HIV and Hepatitis

1 that's killing West Virginians today and causing
2 much more difficult problems in their lives.

3 Education would be important as well.
4 And making sure that fewer pregnant women are -- or
5 pregnant women are connected -- being connected to
6 treatment during pregnancy or having fewer babies
7 with NAS as a result.

8 So all of those strategies that would
9 help us address the problem we're facing today in
10 the state of West Virginia.

11 Q. And just to be clear, you are not offering
12 opinions in that other matter, to your knowledge,
13 about what caused the opioid crisis. Is that
14 correct?

15 A. That's correct.

16 Q. Doctor Gupta, I'm going to ask that Exhibit
17 58 be put up on the screen. I'm just going to give
18 you a moment to take a look at it, please.

19 MS. MAINIGI: Exhibit 58 is
20 Plaintiffs' Supplemental Federal Rule of Civil
21 Procedure 26(a)(2)(C) Disclosure, for the record,
22 and I believe it's Exhibit 1 to docket No. 1146
23 dated October 23rd, 2020.

24 MR. RUBY: And Teresa, this is marked

1 -- we'll get you -- this is a new exhibit that
2 wasn't in the last depo, so we'll get you this and
3 the other new ones after the depo today.

4 MS. MAINIGI: And for the record, I
5 will just note that the only -- the only thing
6 we've done with Exhibit 58 that makes it different
7 than what the plaintiffs filed, is we've added some
8 numbers at the beginning next to the bullet points
9 just so it's easier, Doctor Gupta, for you and I to
10 refer back to different ones of these.

11 That's all we've done, and they've
12 been added, at least in the copy that I see, in red
13 here.

14 GUPTA DEPOSITION EXHIBIT NO. 58

15 (Plaintiffs' Supplemental Federal Rule
16 of Civil Procedure 26(a)(2)(C)
17 Disclosure (marked with red numbers)
18 was marked for identification purposes
19 as Gupta Deposition Exhibit No. 58.)

20 BY MS. MAINIGI:

21 Q. Doctor Gupta, take a moment, if you need
22 to. But do you recognize this document?

23 A. I'm looking at it now. I could read
24 through it.

1 Q. Do you see, Doctor Gupta, that this
2 document reflects that it is a summary of your
3 opinions?

4 A. The page in front of me right now, yes.

5 Q. Okay. Have you seen this document - and I
6 don't mean the version with numbers, but have you
7 seen any version of this document - before today?

8 A. No.

9 Q. Did you sit down with your attorney or
10 attorneys and prepare a document of this type, to
11 your recollection? I don't need to know about the
12 conversation; I'm just asking if you had a process
13 of sitting down with your attorneys to prepare such
14 a document.

15 A. No.

16 Q. Were you aware this document had been
17 prepared on your behalf?

18 A. It may have been referred to, that there
19 are some points, but I was not aware of specific.
20 I'm seeing only Bullet Points 1 and 2.

21 Q. We can go ahead and scroll through the rest
22 of the document so you can have a feel for it.

23 MR. RUBY: And Doctor, I can stop if
24 you want to review particular points here. Tell me

1 what would be helpful to you.

2 THE DEPONENT: If you could just go
3 back up a little bit, just slowly, from No. 3 on
4 down.

5 MR. RUBY: Tell me when you're ready
6 to move on down.

7 THE DEPONENT: Okay.

8 MR. COLANTONIO: I'm sorry, what was
9 the question?

10 MS. MAINIGI: Well, if there's one
11 pending - which I can't remember - I'll withdraw it
12 and ask this question:

13 BY MS. MAINIGI:

14 Q. Doctor Gupta, now that you've had a moment
15 to review this document, does it refresh your
16 recollection that you participated at all in its
17 preparation?

18 MS. KEARSE: I think he's still
19 reviewing it.

20 THE DEPONENT: Yeah, just if we could
21 move down to 9, please.

22 A. So my answer would be no.

23 Q. I'm sorry?

24 A. My answer would be no.

1 Q. Thank you. Just perusing these statements
2 -- and I'm not asking you to review them chapter
3 and verse. We will do that shortly. But do they
4 generally look like some of the things you happen
5 to have said at your last deposition?

6 A. I think they're fairly close to -- so my
7 point of view.

8 Q. And your point of view, you -- I assume
9 you'll agree with me that some of these statements
10 are just pure facts that could be proven or
11 disproven, correct?

12 A. I'm sorry, facts that can be disproven?

13 Q. Well, facts that can be empirically proven
14 or disproven, correct?

15 A. I would say my statements stand for
16 themselves as they are.

17 Q. Well, I guess let me ask it this way: Some
18 of these statements are facts and some are
19 opinions. Correct?

20 A. I'm happy to go through these and we can
21 discuss. I can't give you an opinion one way or
22 the other for all of the points.

23 Q. Fair enough. Fair enough. Before we start
24 getting to some of these opinions, can we go to

1 Footnote 27, please?

2 A. I'm going to move the video box out here so
3 I can read.

4 Q. Sure. Let me know when you're done reading
5 Footnote 27.

6 A. So I'm done reading Footnote 27.

7 Q. Okay. Let me ask you about the first
8 statement in Footnote 27. It says you are a
9 "practicing internist with 25 years of clinical
10 experience." Is that correct?

11 A. I'm going to calculate the years and get
12 back to you. I began practice in 1993 originally,
13 so that would be a little more than that, if we
14 calculated from there.

15 So that's more like - 21 plus 7 - 28
16 years. If you look at post residency, that's 1999,
17 that would be about 22. So yeah, 22 to 27 years,
18 which makes 25 right in the middle.

19 Q. And that's 25 or 22 to 27 years as a
20 practicing internist, correct?

21 A. Correct.

22 Q. The footnote also notes that you have
23 authored more than 125 peer-reviewed scientific
24 publications. Is that accurate?

1 A. That's correct.

2 Q. How many of them have to do with opioids?

3 A. I couldn't tell you right here.

4 Q. Would it be fair to say maybe one has to do
5 with opioids?

6 A. I think it would be very difficult for me
7 to venture that guess right now.

8 Q. Let's go to your CV. And let's go to page
9 27, Item No. 27. Can you describe Item No. 27 on
10 page 27 of your CV, please, Doctor Gupta?

11 A. I can just read that out to you. "Gupta,
12 R. Another ill of prescription opioids. Abstract
13 and Commentary. Internal Medicine Alert. 2014;
14 36(9):68-69."

15 Q. Now, was this a peer-reviewed scientific
16 publication?

17 A. This -- generally the Internal Medicine
18 Alert publications are a peer review of a
19 peer-reviewed publication.

20 So generally there will be reviews
21 that will be published as peer reviews, and experts
22 like myself would provide a review of the
23 peer-reviewed material.

24 Q. So you're doing a review of the review; is

1 that right?

2 A. As an expert.

3 Q. Okay. And the Internal Medicine Alert, is
4 that essentially an online newsletter for
5 internists?

6 A. It may be online, but I have also seen
7 paper versions of it. It has a distribution of
8 about 200,000 primary care physicians and
9 internists all over the country.

10 Q. The work for this, Another ill of
11 Prescription Opioids piece, that wasn't research
12 you did yourself, correct?

13 A. The abstract and commentary that I would
14 have written would be the research I would have
15 done myself.

16 Q. What research did you do for this
17 commentary?

18 A. Ms. Mainigi, I sitting here, I could not
19 tell you what research I did seven years ago for a
20 random article that is in my list -- my CV at this
21 point. I'd be happy to go back and look it up and
22 get you the answers, but I just couldn't -- I'm
23 sorry, I don't have that type of memory.

24 Q. And that's fine, Doctor Gupta. But just to

1 confirm, this -- this was one of those reviews of a
2 review that you mentioned?

3 A. That's what I just stated.

4 Q. Okay. And so then the manner in which you
5 did this is: There was a review that was done, and
6 you reviewed that review, correct?

7 A. I will -- I'm happily able to restate this
8 now for the record, which is: Generally what
9 happens is that there are all kinds of publication,
10 review articles, clinical trials and other
11 peer-reviewed literature that is published in the
12 field of medicine at large.

13 The -- the editor in chief of the
14 magazine, of this particular journal, requests
15 particular -- those of importance -- significant
16 importance, articles that are out there, requests
17 the editorial board to -- for those particular
18 pieces, to review that, conduct research around
19 that article, conduct parallel research of other
20 articles, and then use their expertise and
21 specialty and experience to put together an
22 abstract and a commentary, which is then further
23 reviewed by the editor in chief. So it is peer
24 reviewed, and then it gets published into this

1 journal called Internal Medicine Alert.

2 That would be a very similar process
3 for not just this, but other publications of
4 similar nature on my resume as well.

5 Q. And so I think there is a number of items,
6 of which this is one, on your resume that you
7 describe as peer-reviewed publications. That's
8 generally what you mean by that, what -- the
9 definition you just gave, correct?

10 A. I just explained it.

11 Q. Going back to Footnote 27, please --

12 MR. RUBY: Coming.

13 Q. -- this footnote also notes, Doctor Gupta,
14 that you are a "national and global leader in
15 transforming public health practice to advance
16 health equity and create healthier communities."
17 Do you see that?

18 A. Yes.

19 Q. And do you agree with that statement?

20 A. Yes.

21 Q. The last sentence notes that you were named
22 West Virginian of the year for your work toward
23 battling the opioid epidemic by the Pulitzer prize-
24 winning Charleston Gazette-Mail. Do you see that?

1 A. I see that.

2 Q. Is that accurate?

3 A. That's accurate.

4 Q. What was the work that caused you to be
5 named West Virginian of the Year?

6 A. I'm happy to go into the details of the
7 work. This was in -- something that was -- this
8 happened in December, end of 2017. That would have
9 been included with my work from 2015, '16 to '17.
10 I'll start with the high points.

11 Q. Let me just interrupt you for one moment,
12 Doctor Gupta, because I want to get into the
13 details in a little bit.

14 MR. COLANTONIO: Do you want him to
15 finish his answer, please?

16 MS. KEARSE: Yeah, Enu, can he
17 complete his answer, please?

18 Q. Well, what I'll ask you, Doctor Gupta, is
19 just give me the high level, and then we're going
20 to come back in greater detail later.

21 MS. KEARSE: Well, Enu, you had a
22 question pending and specifically asked him about
23 this award, so I think he can answer as complete as
24 he --

1 MS. MAINIGI: Okay, that's fine.

2 Q. Go ahead, Doctor Gupta.

3 A. So basically my work from 2015 and '16 and
4 '17, it was the totality of the work that was
5 recognized for this award. That really required a
6 asserted effort from day one, so going back, very
7 beginning, one of the first -- when I came into the
8 office in January of 2015, it became my priority
9 number one, priority number two and priority number
10 three, to start addressing or help address the
11 problem of the overdose deaths that we were facing,
12 as well as the nonfatal overdoses and the carnage
13 and the killing that was happening in West Virginia
14 around the clock of people because of the opioid
15 crisis.

16 So the first thing we did was: We
17 created the first -- funded the first Harm
18 Reduction Program by providing seed funding to
19 Cabell-Huntington Health Department in Cabell
20 County, so we initiated that program.

21 I helped not only fund, but helped
22 begin that program with Doctor Kilkenny, as I
23 mentioned, worked very closely with Doctor Kilkenny
24 in Cabell-Huntington Health Department.

1 We then continued to utilize the model
2 of Cabell-Huntington Health Department's Harm
3 Reduction Program to expand to other areas of the
4 state. In early 2017, I continued to see 15 to 20
5 percent rise in overdose deaths year after year
6 after year, so along with working to write the 1115
7 Medicaid waiver, expand -- remove the barriers to
8 treatment, work legislation, create the Office of
9 Drug Control Policy at the State level --

10 One of the important things we did is:
11 We conducted a social autopsy. The social autopsy
12 that was conducted, we looked at all of the deaths
13 from overdose that happened in 2016. We -- we did
14 a CSI type of investigation to look at people's
15 deaths in the year before their deaths.

16 We had very significant findings that
17 included that 90 percent of decedents have an
18 interaction with the -- you know, the PDMP or the
19 prescription drug monitoring -- Controlled
20 Substances Monitoring Program in West Virginia, as
21 we call it, and we found that a significant
22 percentage of women -- so half of the women that
23 died had filled a prescription within 30 days of
24 their death.

1 We also found that if people went to
2 multiple pharmacies, that chances was as high as 70
3 percent of dying because of overdose. We -- so we
4 had very significant findings like these, because
5 of which then we -- I put together a team to create
6 an opioid response plan of national and state
7 experts, including John Hopkins University,
8 Marshall University and West Virginia University.

9 They came out with a plan, 12-point
10 plan. We -- I submitted that plan to the Governor.
11 As a result of this, basically -- and I don't want
12 to like take too much of this time. But what
13 happened was: Before I came, the rate of
14 prescription drugs and after I left, in the
15 country, it was down by 30 percent; in West
16 Virginia, because of these efforts, it was down by
17 53 percent.

18 In 2017 to 2018, because of the work
19 of 2017, the paper was recognized nationally, the
20 outcomes that would happen. That was the only
21 year, from 2017 to 2018, that the nation had any
22 drops in overdose deaths, and nationally, there was
23 a drop of about 4 percent average. But in West
24 Virginia, because of this work, we had 11 percent

1 drop, literally three times the drop we had of the
2 national average.

3 And those are some of the reasons
4 that -- the Gazette, Politico, PBS, a number of
5 venues, publicly recognized the work and provided
6 -- and as well as the Governing magazine and some
7 others.

8 Q. So in your role as State Health
9 Commissioner, you were able to have an impact on
10 the opioid crisis. Fair?

11 A. I would say significant, yeah.

12 Q. Now, the West Virginian of the Year award
13 in 2017, was that just you that won that award?

14 A. No, there were other colleagues as well. I
15 don't remember exactly who the other colleagues
16 were, but there were other colleagues. Some years,
17 it's given to one person; other years, it's given
18 to multiple people.

19 Q. So you weren't the sole West Virginian of
20 the Year, right?

21 A. Right.

22 Q. Okay. Do you recall that in fact the 2017
23 West Virginian of the Year award was given to
24 everyone who was working to combat the opioid

1 epidemic?

2 A. You know, of the 5,000 employees at DHHR, I
3 do not recall that everybody was given that award.

4 Q. Okay.

5 MS. MAINIGI: Let's put up Exhibit 61,
6 please.

7 Q. And Exhibit 61 is 12-31-17 Charleston
8 Gazette-Mail written by Erik Eyre, "Men and women
9 battling the opioid epidemic."

10 GUPTA DEPOSITION EXHIBIT NO. 61

11 (Charleston Gazette-Mail article dated
12 12-31-17 entitled "Men and women
13 battling the opioid epidemic" was
14 marked for identification purposes as
15 Gupta Deposition Exhibit No. 61.)

16 Q. And do you see at the top there that
17 there's a feature -- there's reference to
18 Huntington Fire Chief Jan Rader?

19 A. Yes.

20 Q. Okay. And do you see where it says, "Rader
21 is one of thousands of West Virginians staring down
22 the opioid crisis?"

23 A. Yes. Could you --

24 THE DEPONENT: Can you just move the

1 slide up a little bit? Because it's covering up
2 the top pieces of this manuscript. The top.

3 Q. Do you see where it says, "Rader is one of
4 thousands of West Virginians staring down the
5 opioid crisis," Doctor Gupta?

6 A. I do not, actually.

7 Q. Let's highlight it for you.

8 A. Yeah, I --

9 Q. You see it now?

10 A. Yeah. I would really request to see the
11 entire document rather than reading one sentence.

12 Q. Well, do you see where we've highlighted,
13 Doctor Gupta?

14 A. I can see the highlight.

15 Q. Okay. And what does the highlight --

16 MS. KEARSE: If Doctor Gupta wants to
17 review the whole document, please allow him to
18 review the document. And I'm sure he doesn't --
19 he'll answer your questions, but --

20 MS. MAINIGI: Well, he certainly can
21 review the document in a moment, but I'm just
22 asking if he -- if he sees where it says -- it's
23 highlighted now.

24 MS. KEARSE: Enu, with all due

1 respect, I believe he should be able to look at the
2 document before you answers a question about the
3 document so he can put it in context.

4 MS. MAINIGI: Okay. But I'm just
5 asking him, Anne, and I don't want to argue back
6 and forth with you, because we're not supposed to
7 do that.

8 BY MS. MAINIGI:

9 Q. Doctor Gupta, do you see where it says,
10 "Rader is one of thousands of West Virginians
11 staring down the opioid crisis." Do you see that?

12 A. Ms. Mainigi, you're not making me feel
13 comfortable by not allowing me to be comfortable
14 understanding the entire document.

15 Q. Do you see the highlighted paragraph,
16 Doctor Gupta?

17 A. Ms. Mainigi, I do see the highlighted
18 paragraph, but I am not comfortable the way I'm
19 being treated right now.

20 Q. Okay. Let me read the highlighted
21 paragraph to you, Doctor Gupta. It reads as
22 follows: "Rader is one of thousands of West
23 Virginians staring down the opioid crisis. They
24 are firefighters, police officers, social workers,

1 paramedics, emergency medical technicians, nurses,
2 doctors, pharmacists, counselors, emergency room
3 workers, psychologists, detoxification center
4 employees, public health officers, people in
5 recovery, and families who've lost loved ones to
6 addiction and now provide comfort and a helping
7 hand to others. They're all working to combat the
8 opioid epidemic.

9 And they are the Gazette-Mail's West
10 Virginians of the Year for 2017."

11 Did I read that paragraph correctly,
12 Doctor Gupta?

13 A. Abstract-wise, yes.

14 MS. MAINIGI: We can take that off the
15 screen.

16 MS. KEARSE: No, no, Enu, you can't
17 take it off the screen now. He just asked to
18 review the document, so --

19 MS. MAINIGI: He can certainly review
20 the document at the next break, Anne, if he would
21 like. I'm moving on.

22 MS. KEARSE: Let's take a break --

23 THE DEPONENT: Then, Ms. Mainigi, I
24 can't continue this dep --

1 MS. KEARSE: Let's take a break right
2 now so he can review the document -- and Steve, if
3 you sent -- I don't know if I got that -- I don't
4 see that on my e-mail that you sent me that
5 document anyway, but --

6 THE DEPONENT: I would like to take a
7 break.

8 MS. MAINIGI: I don't have anything
9 more. This is --

10 THE DEPONENT: I'm requesting a break.

11 MS. KEARSE: We're going to take a
12 break right now, Enu. Can we take a break, please?

13 MS. MAINIGI: Okay. Hang on one
14 second. Let me see where I am on my outline. Yes,
15 we can take a ten-minute break. Is that okay?

16 THE DEPONENT: I want to take a
17 fifteen minute break.

18 MS. KEARSE: Okay.

19 MS. MAINIGI: Well, I hope then
20 Mr. Gupta can stay past 4:00 o'clock because we've
21 got to keep the breaks tight since you gave us
22 limited time.

23 MR. COLANTONIO: He'll agree to ten
24 minutes past 4:00 o'clock if that's a problem,

1 since we're going to take fifteen minutes instead
2 of five. How's that?

3 THE DEPONENT: Ten. Fifteen instead
4 of ten.

5 MR. COLANTONIO: Yeah, five minutes,
6 yeah.

7 MS. MAINIGI: Okay, it's 12:54. And
8 we'll be back in fifteen minutes then. How about
9 by 1:10, we're back. Is that all right?

10 MS. KEARSE: Yeah, we can go off the
11 record. Enu --

12 VIDEO OPERATOR: Going off the record.
13 The time is 12:54 p.m.

14 (A recess was taken after which the
15 proceedings continued as follows:)

16 VIDEO OPERATOR: We're going back on
17 the record. The time is 1:10 p.m.

18 MR. COLANTONIO: Yeah, so just before
19 we start, I'd like to --

20 MS. KEARSE: Enu, I want to raise one
21 issue before we go back on the record, and we've
22 been doing depositions now for a long time, and I
23 know you're well aware of the deposition protocol,
24 that we're all doing every accommodation we can

1 have for you to provide Doctor Gupta and to get the
2 exhibits there. There are provisions that he
3 should have a hard copy document in addition to be
4 able to read the document beforehand, so I ask you
5 to please at least --

6 You know, since we did not get these
7 exhibits, some of these exhibits, in advance, nor
8 even get notice of this exhibit, please, with, I
9 guess, just a common courtesy, to let the doctor
10 review the exhibit in totality before you ask
11 questions there, and also it's part of the
12 protocol. It's common in professional courtesy as
13 well.

14 MS. MAINIGI: And Anne, certainly, for
15 the record, I think most exhibits were e-mailed to
16 you all, and it was understood by us that you would
17 be printing them out for Doctor Gupta's use. We
18 found out at the beginning of the deposition that
19 was not going to be the case, but --

20 MS. KEARSE: Well, we didn't get -- we
21 did not get Exhibit 61, for the record, so -- but
22 go ahead.

23 MR. COLANTONIO: And let me also just
24 say that during the break, Doctor Gupta's had now a

1 chance to review the full document, and so he'd
2 like to finish his answer regarding that particular
3 document.

4 MS. MAINIGI: I will certainly --
5 after 4:00 o'clock, if you want to ask him about --

6 MR. COLANTONIO: Go ahead, Doctor,
7 just put your statement on the --

8 MS. MAINIGI: No, no, no, no.

9 THE DEPONENT: I just wanted to say
10 that I did have a chance to --

11 MS. MAINIGI: Doctor -- Doctor Gupta,
12 stop talking.

13 (Overtalk)

14 THE DEPONENT: I want to --

15 MS. MAINIGI: Doctor Gupta, please
16 stop talking. There is no question pending right
17 now, and after having rehearsed an answer with your
18 attorneys, I do not need you - with all due
19 respect, sir - to come in and give me your
20 rehearsed answer.

21 MR. KEARSE: Enu, for the record, this
22 is Anne defending this deposition. You actually
23 stated that he could review the document on the
24 break. He reviewed the document on break and now

1 he's able to finish his questioning regarding your
2 questions about this document.

3 So I think it's quite appropriate now
4 that he's reviewed it. You didn't let him review
5 it while he was on the record, so he's now reviewed
6 it, so if he just --

7 MR. COLANTONIO: I just want to place
8 on --

9 MS. MAINIGI: Okay, Doctor --

10 MR. COLANTONIO: Hold on a second. I
11 want to place on the record that I object to your
12 statement that somehow there's a rehearsed answer,
13 and I take umbrage to that, and just for the
14 record, I want to put that on the record.

15 MS. MAINIGI: Okay, understood.

16 BY MS. MAINIGI:

17 Q. Doctor Gupta, could you please pull out
18 Exhibit 58 again? I don't know if your counsel has
19 printed it out for you now, but it is -- it is the
20 statement that they filed with the Court with all
21 of your opinions that has led to this deposition.

22 Let me know if you just want it on the
23 screen, and we are happy to leave it on the screen.

24 A. It's already on the screen.

1 Q. Okay, terrific. I'm going to ask you about
2 the first bullet, and that first bullet reads as
3 follows: "Opiate prescription drugs, their volume,
4 and the consequential addiction and other diseases
5 associated with OUD rose by thousands of percent
6 over a decade."

7 Did I read that correctly?

8 A. That's what it says.

9 Q. Do you agree with this statement?

10 A. I'm not sure if I agree with the entirety
11 of the statement.

12 Q. Okay. What part of the statement -- and I
13 don't need the reasons yet, we can break that down,
14 but what part of the statement do you agree with or
15 disagree with?

16 A. I don't agree with the statement, period.

17 Q. Okay. So let me just ask you one follow-up
18 question on that and then we can move on to another
19 opinion of yours. Where it says "thousands of
20 percent over a decade," do you have any idea what
21 decade is referenced there?

22 A. Ms. Mainigi, you're providing me this
23 document. I don't have -- you know, I'm -- you're
24 asking me a question if I agree to the statement.

1 I said I don't agree with the statement. So you're
2 welcome to ask me questions, but I can't guess what
3 you're thinking.

4 Q. Okay. Do you recall making this statement
5 at your last deposition?

6 A. I do not.

7 Q. Okay. So you don't know what -- just for
8 the record, the word "decade" in that statement,
9 the first bullet, you don't know what decade is
10 being referred to there.

11 A. I would request to you once again, after
12 the break now, that if you intend to show me a
13 statement, please provide me the context, because
14 it's really unfair and misleading for me to be able
15 to react to a statement without having any context,
16 and you're doing it again.

17 Q. Okay.

18 MS. KEARSE: Enu, if you want to show
19 him the page numbers on the deposition --

20 MS. MAINIGI: I don't. I'm just going
21 to go off of this document that you all filed on
22 his behalf, Anne.

23 Q. Okay. So let's move on to --

24 MS. KEARSE: You referred to his

1 testimony, so -- in his deposition, so --

2 MS. MAINIGI: Please, Anne, I'd
3 appreciate it if you'd not have a speaking
4 objection.

5 MR. FARRELL: Hold on, hold on. Enu,
6 this is Paul Farrell. This isn't a speaking
7 objection. What I'm saying is that the back and
8 forth, we are both having objections to.

9 We did not file this document on his
10 behalf. This is a document that we filed to give
11 disclosure to the Court about the opinions that he
12 offered during his deposition that we anticipated
13 he would say at trial.

14 So I think that everybody is getting a
15 little loose with their words and accusations, and
16 so we will respect you and your questions, and I
17 ask that you do the same, and so representing this
18 document to be something that it's not, I object
19 to.

20 MS. MAINIGI: Okay. Thank you, Paul.

21 BY MS. MAINIGI:

22 Q. Doctor Gupta, if you could take a look at
23 the sixth bullet which is labeled by us 6, and just
24 take a moment and read that, please, sir.

1 A. Okay.

2 Q. The sixth bullet reads as follows: "The
3 HIV outbreak in Cabell County, as a result of IV
4 drug use, is the second largest in the nation's
5 history." Do you agree with that statement?

6 A. I'd have to know more about what you're
7 talking about.

8 Q. Do you recall making a statement of this
9 type at your last deposition, Doctor Gupta?

10 A. Once again, Ms. Mainigi, if you have my
11 deposition, please be transparent and show it to
12 me. I can't recall every word of my deposition.

13 Q. I'm sure you can't. Doctor Gupta, let me
14 just represent to you that the plaintiffs in this
15 matter filed -- filed a document which is the
16 document in front of you, and represented that
17 these were opinions and factual statements of yours
18 that they derived from your prior deposition.

19 A. You have me right here. You can ask me
20 directly.

21 Q. Okay.

22 A. You don't have to --

23 Q. I'm going to keep doing that, Doctor Gupta.
24 Thank you.

1 Okay. Are you aware of an HIV
2 outbreak in Cabell County that was the second
3 largest in the nation's history?

4 A. Please be more specific.

5 Q. I cannot be. If you're not able to answer
6 that question, that's fine, Doctor Gupta. I'll
7 move on.

8 A. I'll be happy to answer if you provide me
9 the context and the specifics.

10 Q. Are you aware of any HIV outbreak in Cabell
11 County that was a result of IV drug use?

12 A. Yes.

13 Q. And what can you tell me about that?

14 A. I would have to recollect by memory, and I
15 do not have a very good recollection to provide you
16 any meaningful information other than there was an
17 HIV outbreak related to IV drug use in Cabell
18 County.

19 Q. And do you -- can you give me an
20 approximate year?

21 A. It may have been in 2018 or '19. I do not
22 recollect at this point.

23 Q. And do you believe that outbreak was the
24 result of IV drug use?

1 A. That's my recollection.

2 Q. And what do you base that understanding on,
3 that that HIV outbreak was the result of IV drug
4 use?

5 A. On my memory.

6 Q. Did you compile any underlying information
7 related to the HIV usage and the IV drug use and
8 the correlation between those two?

9 A. Are you speaking specific to the outbreak,
10 or overall my responsibilities as the State Health
11 Commissioner or my responsibility as the County
12 Health Officer?

13 Q. Specific to the outbreak.

14 A. As I said before, I do not have a really
15 good recollection to a point I can provide you
16 informed information at this point. If you'd give
17 me the documents, I'm happy to share with you my
18 opinion.

19 Q. What documents would you need?

20 A. Whatever you're alleging. Whatever you
21 just stated, the compilation of reports,
22 investigations. I'm happy to look at those.

23 Q. Unfortunately, I don't have anything
24 besides this, Doctor Gupta. But let's move on.

1 Let's go to the bullet that has a 10 in front of
2 it. Take a moment, please, and read that bullet.
3 Let me know when you're ready for me to ask you
4 questions.

5 A. One second.

6 Q. Sure.

7 A. Okay, I've read that.

8 Q. Let me just read it out loud -- excuse me.
9 -- out loud for the record. Excuse me. "Because
10 of the overwhelming number of overdose deaths in
11 2015, there was a need in West Virginia for
12 air-conditioned trailers to house the bodies of
13 those who had overdosed."

14 Did I read that correctly?

15 A. Yes.

16 Q. Do you agree with that statement?

17 A. Yes.

18 Q. And that is a statement of fact, correct?

19 A. Correct.

20 Q. What is your source of information for that
21 statement of fact?

22 A. So I was also overseeing the chief medical
23 office of -- the Office of the Chief Medical
24 Examiner and one of the things we had to do was

1 purchase trailers - now, I could not tell you if
2 they were air conditioned or had fans or what in
3 them - but we had to purchase trailers to be able
4 to house the dead bodies that were coming one every
5 8 hours to 12 hours because of the overdose deaths
6 resulting from -- you know, obviously from drug
7 overdose.

8 So we had to do that in the years
9 during my tenure.

10 Q. And do you specifically remember doing that
11 in 2015?

12 A. I specifically don't remember at this time,
13 but I do clearly remember doing it.

14 Q. Okay. And in 2015, the drug overdose
15 deaths were from what drugs mainly?

16 A. I couldn't tell you right now. I mean, I'd
17 be happy to look at the charts that we produced,
18 the report I looked at from 2000-2015. I mean --
19 but broadly without reviewing the data right now, I
20 could tell you they were generally a combination of
21 opioid prescriptions, heroin and fentanyl as well
22 as other polysubstance use.

23 Q. Do you remember being deposed in 2016?

24 A. I don't remember the exact deposition.

1 Q. Okay. And I'm sorry, let me -- let me give
2 you a little bit more than that. Do you recall
3 that you were deposed in 2016 in an opioid case?

4 A. Yes.

5 Q. Now, I will represent to you that your
6 deposition in 2016 did not mention that the Office
7 of Medical Examiner had needed air-conditioned
8 trailers in 2015. Is there a reason you omitted
9 that fact from your 2016 deposition?

10 MS. KEARSE: Objection.

11 A. I don't recall if the defendants asked me
12 that question specifically.

13 Q. Let's move on -- I'm just jumping around a
14 bit. But we'll cover all of these, Doctor Gupta.
15 Let's move on to Statement No. 13, if you would,
16 please, sir. And if you'd take a moment and just
17 read that.

18 A. I've read it.

19 Q. Let me read that out loud for the record.
20 "In 2016, a significant amount of the people who
21 died from an overdose had filled a prescription
22 within 30 days prior to their death." Do you agree
23 with that statement, Doctor Gupta?

24 A. Those are findings of the facts.

1 Q. And they are findings of fact from where or
2 what?

3 A. From the social autopsy report we published
4 which is available for you to review.

5 Q. Okay. I believe that was one of the
6 exhibits that was e-mailed to your attorneys last
7 night.

8 MS. MAINIGI: I'm assuming you all
9 still have not printed out any of those documents,
10 so we can put that up on the screen for you.

11 What exhibit number should we use for
12 that? 62?

13 MR. RUBY: This was already marked as
14 Plaintiff's 2 from the September deposition.

15 MS. MAINIGI: Oh, terrific. Okay, so
16 we will leave it as Plaintiff's 2. It's a
17 plaintiff's document.

18 BY MS. MAINIGI:

19 Q. Was that fact, Doctor Gupta, from this
20 report, the 2016 West Virginia Overdose Fatality
21 Analysis?

22 A. Yes.

23 Q. And several of the facts in this document
24 that we've been reviewing are from this report.

1 Does that sound right to you?

2 A. I'd have to go back and check each one.

3 Q. Okay. Now, you ordered this report while
4 you were commissioner and State Health Officer; is
5 that correct?

6 A. So one of the -- one of the roles that we
7 omitted today talking about the role of the
8 Commissioner/State Health Officer is actually the
9 obvious, which is to commission reports. And this
10 was certainly one of the several reports I had
11 commissioned to be conducted because I was so
12 terrified of the deaths that were happening because
13 of overdoses around the clock in the state of West
14 Virginia when I assumed office.

15 Q. Okay. Let's turn to the third page of the
16 report. This is the third page of the report,
17 Doctor Gupta, and the third page lists the people
18 who prepared the report, correct?

19 A. Will you allow me to review the whole page,
20 please?

21 Q. Sure. Go ahead.

22 A. Thank you. I just want to see the corners
23 of the page, make sure -- the bottom corner, those
24 are all the people.

1 Yes, it does.

2 Q. Okay. And is it fair to say the lead
3 authors of this report were Sarah Sanders, from the
4 Violence and Injury Prevention Program and
5 Christina Mullins from the Office of Maternal,
6 Child and Family Health. Is that correct?

7 A. If you would move to the first page, it
8 also has a couple of names on there. I just want
9 to make sure there's no conflict there. The page
10 before this. Sorry.

11 Yeah. So yeah, at the bottom of this
12 first page, you have two names. Those are the same
13 as the ones you mentioned, so the answer is yes.

14 Q. Those are -- those two individuals are the
15 primary authors of the report. Correct?

16 A. We -- yes, we generally list the primary
17 authors on the first page.

18 Q. And then the third page also lists perhaps
19 16 or so people who supported the report in some
20 fashion. Correct?

21 A. This was a multi-disciplinary,
22 multi-faceted report, and so all of these
23 individuals played a critical role in the
24 publishing of this report.

1 Q. And your name is not listed among these
2 individuals, correct, Doctor Gupta?

3 A. As the Commissioner who commissions the
4 very execution of the report, it would -- I would
5 not be listed as also the preparer, writer or
6 investigator of the same report.

7 Q. And you didn't -- as the commissioner of
8 the report, you didn't perform any of the analyses
9 in the report then, correct?

10 A. I provided the guidance.

11 Q. And what was the guidance you provided for
12 this report?

13 A. I provided the guidance of the year of the
14 report, the weight of the report, meaning the
15 epidemiological guidance that was acquired in order
16 for this to be conducted.

17 I provided the ability for us to have
18 direction and facilitate the work of this report,
19 basically, and clearly this was a report that was
20 interagency report, so I was -- I had -- when we
21 talked about this report, this was not just a --
22 data that came from the Bureau of Public Health.

23 It involved work and data from the
24 State Medicaid agency, EMS agency, Medical

1 Examiner's Office, Department of Military Affairs
2 and Public Safety. And a number of others. So it
3 was very critical to have the highest level of
4 direction and relationships.

5 So I was responsible for overseeing
6 every and all aspects of this report, including
7 engaging the Centers for Disease Control and
8 Prevention.

9 Q. Does it say somewhere in here what you just
10 said, that you were responsible for engaging on
11 every part of this report?

12 A. Ms. Mainigi, that's what state health
13 commissioners do across this nation.

14 Q. Let's go to the prior page where your name
15 is. And this page lists also Jim Justice, The
16 Governor; Bill Crouch, Cabinet Secretary for the
17 Department of Health and Human Resources; obviously
18 you; and then Jim Johnson, Director of the Office
19 of Drug Control Policy; Anne Williams, Deputy
20 Commissioner, Health Improvement Bureau for Public
21 Health; Christina Mullins, Director for the Office
22 of Maternal, Child and Family Health.

23 Do you see that?

24 A. Yes.

1 Q. Did all of these individuals also engage in
2 the way that you described your engagement?

3 A. My engagement was fulfilling the role of
4 the Commissioner. Other individuals did not have
5 that responsibility. They had very important roles
6 to play, but not one of the Commissioner and State
7 Health Officer for the State of West Virginia.

8 Q. Coming back to the statement that is
9 numbered 13 on Exhibit 58, please, can you tell me
10 what the phrase "a significant amount" refers to?

11 A. Certainly. Let's go back to that report.

12 Q. Well, I'm just asking if you know sitting
13 here, Doctor Gupta, what "a significant amount"
14 refers to.

15 A. I'm asking you, sitting here, please, let's
16 go back to that report, because that's where the
17 answers are.

18 Q. Okay. The answers are in the report?

19 A. Of course. You just mentioned that a lot
20 of these bullets came from that report, so I'm
21 reading out of your statement back to you, and
22 that's a -- that's true.

23 Q. Okay. And is it fair to say that you
24 wouldn't be able to tell me what "a significant

1 amount" refers to without aid of that report then?

2 MS. KEARSE: Objection.

3 A. I think it's fair to say that I would like
4 to make sure I have access to the report. Let's go
5 back to the facts and look at it rather than to --
6 to err on the side of facts, being able to look at
7 the report.

8 Q. Okay. So Doctor Gupta, let me ask my
9 question again. Is it fair to say that without the
10 aid of the report, you're not able to tell me what
11 the phrase "a significant amount" in this bullet
12 means?

13 MS. KEARSE: Objection.

14 A. I can tell you, but I would like to be
15 certain. And I -- I mean, look, I can tell you.
16 What that means is: For women, about 49 percent of
17 women have died within 30 days of filling a
18 prescription; for men, it was, I believe, around 36
19 percent that died within 30 days of filling a
20 prescription.

21 But I really hope you stick to the
22 facts of the report and not my memory from several
23 years ago. But it's up to you.

24 Q. Okay, understood. And assuming that those

1 numbers are correct, your 49 percent and your 36
2 percent, those are statements of fact, not opinion,
3 correct?

4 A. That's correct.

5 Q. And the data that went into compiling those
6 numbers, that was data that was compiled presumably
7 by the authors of the report?

8 A. Correct.

9 Q. And the statement related to the
10 significant amount, or the 49 percent or the 36
11 percent, was that a number state-wide?

12 A. Yes.

13 Q. And you don't know whether that number was
14 specifically true for Cabell or Huntington,
15 correct?

16 MR. COLANTONIO: Objection.

17 A. Sitting here, I do not have that
18 recollection.

19 Q. Okay. And let me --

20 Someone objected to the form of my
21 question, so let me ask it separately. You don't
22 know if the numbers in that report, the 2016 West
23 Virginia Overdose Fatality Analysis applied
24 specifically to Cabell County, correct?

1 A. I could not tell you my recollection of
2 which percentage of those or what percentage
3 applied to Cabell County and City of Huntington at
4 this time.

5 Q. And do you know whether the statement about
6 overdose deaths caused by opioid -- is the
7 statement related to overdose deaths caused by
8 opioids or by all substances?

9 A. The controlled substances. The -- what we
10 did was: We saw the interaction with the
11 Controlled Substance Monitoring Program, which is
12 the West Virginia's version of prescription drug
13 monitoring program, and as we interrogated the
14 CSMP, as we call it, against the deaths, those were
15 the numbers that came about.

16 And generally when we speak about
17 controlled substances in West Virginia, that, once
18 again, generally refers to opioids because of the
19 significant volume of opioids both in prescribing
20 as well as in diversion that existed at the time.

21 Q. Can you define "diversion" for me just so
22 we have it for the record, Doctor Gupta?

23 A. Sure. Diversion of any substance or any
24 medication is the use of that for purposes any

1 other for -- any other than for prescribed use,
2 legitimate prescribed use.

3 Q. And is diversion usually illegal?

4 A. Yes.

5 Q. And is an example of diversion, someone
6 gets a prescription for 30 days, only uses three
7 pills, leaves the bottle in their cabinet and
8 someone who's the not the person for whom the pills
9 were prescribed takes those pills for themselves
10 and utilizes them? Is that an example of
11 diversion?

12 A. That's not the only example, but that could
13 be one example. But the writing of prescriptions
14 that may not be legitimate for someone may also be
15 diversion.

16 Q. What are other examples of diversion that
17 occur to you?

18 A. Borrowing from friends or family. Children
19 getting into the closets -- the drug closets and
20 taking it from their parents is another example.
21 Stealing from each other or from friends or from
22 family is another example.

23 Sometimes when you prescribe 30 days
24 of opioids, you know, Lortab for a tooth pulled and

1 then you leave it in the cabinet after two doses
2 and next month you get a leg sprain and you start
3 to use it again, that's also diversion sometimes of
4 the same person, because that was not the intended
5 use.

6 So there's multiple -- you know, of
7 course, everything from misuse, ill use,
8 illegitimate use, borrowing, to all the way to
9 selling on the street.

10 Q. So diversion generally occurs after the
11 prescription has left the pharmacy; is that
12 correct?

13 A. Not necessarily. If they're being written
14 for a purpose that is less than legitimate, as we
15 have also seen lots of bad doctors writing
16 prescriptions, running pill mills, that's also
17 diversion that happens reportedly when it gets to
18 the pharmacy.

19 Q. The other examples you gave me just in your
20 prior answer, those are examples -- besides this
21 one, those are examples of diversion that occur
22 after the prescription leaves the pharmacy?

23 A. Correct.

24 Q. So the 49 percent and the 36 percent that

1 you mentioned that you recall, I just want to ask
2 you: Is that -- would those numbers, in your mind,
3 be different for overdose deaths caused by opioids
4 versus other substances?

5 A. Not necessarily.

6 Q. Are there different numbers that existed
7 for opioids versus other substances?

8 A. No. We would use synonymously for most
9 purposes controlled substances utilization in CSMP
10 with opioid prescribing for the purposes of this
11 report.

12 Q. Okay. So for the purposes of this report,
13 you didn't necessarily break down into prescription
14 opioids, heroin, fentanyl and so forth.

15 A. No, no, no, that's not what I'm saying.
16 What I'm saying is: When 49 percent of the female
17 decedents -- we found -- so in all the female
18 decedents in the year of 2016 that died from a drug
19 overdose, we found that 49 percent of them had
20 filled a prescription that wasn't a heroin
21 prescription, that was not a meth prescription,
22 that was actually a controlled substances
23 prescription, that's what we found from
24 interrogating the Controlled Substances Monitoring

1 Program.

2 And because of the large -- super
3 large volumes of opioids being flooded into
4 communities through prescriptions, I think it's
5 fair to assume that 49 percent had a very, very
6 high proportion of opioids, if not all.

7 Q. So the report did not determine -- of the
8 49 percent that you reference, the report did not
9 determine who actually died from a prescription
10 opioid abuse versus someone who may have died from
11 a heroin abuse. Correct?

12 A. So we're talking about two different
13 things. All of these people died - they're dead -
14 now we're going back and studying what was the
15 characteristics of that. So if you look back at
16 the report, at the top, it says, you know, we're
17 looking at the medical system, utilization,
18 characteristics of people and all of that. So this
19 is a study that's intended -- the medical examiners
20 already have demonstrated what they died of.

21 Now we're going back and looking at:
22 What were the characteristics of these individuals
23 that died? And we're talking about -- when we talk
24 about 49 percent of women that died had filled a

1 prescription within 30 days of their death,
2 explains that there were still a lot of
3 prescriptions that were being dispensed that were
4 the cause and contributions of death in those
5 individuals.

6 Q. You cannot say - or the report cannot say,
7 as I understand it - that 49 percent of the deaths
8 in those cases were caused by the prescription that
9 was filled within the last 30 days, correct?

10 A. What we can say is: Of the people that
11 died from drug overdose, in those, 90 percent -
12 that means nine out of ten people - had interacted
13 with the Controlled Substances Monitoring Program.
14 And from looking -- within the past year.

15 So nine out of ten people that died
16 had some relationship/interactions with the State's
17 CSMP. Now, when we hone that back to -- from one
18 year to 30 days, we find that almost half of the
19 women that died because of overdose had filled a
20 prescription.

21 Q. But you don't know whether the 49 percent
22 died because of the prescription that they filled,
23 correct?

24 A. This study was not meant to be a direct

1 correlation/causation study, right? So this is not
2 a causation study. So if you're asking me, was
3 there a cause and effect, I would say that was not
4 the purpose of our -- purpose of our work,
5 basically.

6 But from an epidemiological
7 standpoint, our assertions were that there's a
8 reasonable degree of certainty that the continued
9 interaction with Controlled Substances Monitoring
10 Program had high likelihood played a role in the
11 death of these individuals.

12 Q. Let's move on to the next statement, which
13 is Statement 14. If you could take a moment and
14 read that, please, sir.

15 A. I see it. I've got it.

16 Q. Okay. And let me read that statement out
17 loud for the record. "Of the people who were
18 incarcerated, released and subsequently died, the
19 majority died of an overdose." Is that a statement
20 you agree with, sir?

21 A. Yes.

22 Q. What is the genesis of this statement or
23 the source of this statement?

24 A. The same report.

1 Q. Is it the 2016 West Virginia Overdose
2 Fatality Analysis?

3 A. Correct.

4 MS. MAINIGI: If we could put that
5 exhibit back up, please, the 2016 West Virginia
6 Overdose Fatality Analysis. And let's go to the
7 Table of Contents.

8 Q. And while we're doing that, Doctor Gupta, I
9 just want to confirm that you didn't do any
10 independent research on your own to come to this
11 conclusion that is No. 14. You derived the
12 conclusion from the report, the 2016 West Virginia
13 Overdose Fatality Analysis, correct?

14 A. Correct.

15 Q. Okay. Where do you think we could find
16 that statement?

17 A. You could actually do Ctrl-F and find it.

18 Q. What would you like to do Ctrl-F on?

19 A. Incarceration.

20 Q. Do you see any particular section of this
21 report that it would perhaps be included in? We'll
22 see if Ctrl-F works. I don't know if it will.

23 A. Ms. Mainigi, would you like me to pull up
24 this report myself on my computer? Because I would

1 like to really have a fair -- you know, a way where
2 I could see the same thing you guys are seeing,
3 because I feel like I'm being handicapped here.

4 Q. No, and I apologize for that.

5 A. Right there at the bottom. Right there --
6 page -- please go up. Go up, please.

7 MR. COLANTONIO: Back a page. Do you
8 see that?

9 Q. Back a page, okay.

10 A. 18 -- yeah, go up. Move down, I'm sorry.

11 Q. Sorry.

12 A. There is Corrections, right here, 4.4.4, I
13 think. That actually will not be. So I -- maybe
14 3.6. 3.6, page 18 perhaps.

15 Q. Okay. Let's take a quick look, and
16 otherwise we can keep going for now.

17 MR. COLANTONIO: You want --

18 THE DEPONENT: Mine is here.

19 MR. COLANTONIO: I'll get it.

20 THE DEPONENT: Yeah, I can speed this
21 up a little bit.

22 Q. Actually, Doctor Gupta, I ask that you not
23 pull out a computer in the middle of your
24 deposition. I'm asking you to not do that, please,

1 sir.

2 A. Then please provide me that report.

3 Q. Okay, it was provided -- the report was
4 provided to your counsel last night. But I'm just
5 -- right now, let's see what we can do with what we
6 have on the screen. Do you see that fact on page
7 18?

8 A. I don't see that. And please pull that
9 fact up for me. If you have the wheel here, please
10 pull that up and I'm happy to comment on it.

11 Q. Okay. While we --

12 MR. RUBY: This is -- this is Page 18.
13 This is the --

14 MS. MAINIGI: I'm sorry.

15 MR. RUBY: this is page 18. This is
16 what the doctor referred to.

17 MS. MAINIGI: Yeah. I don't see it.
18 Let's go to page 19. Okay, I guess it moves on to
19 something else.

20 Q. Well, it does not appear -- let's -- we'll,
21 on a break, see if we can find it in this report,
22 Doctor Gupta, but let me ask you some information
23 about this statement. Is this statement that you
24 made at your deposition, "Of the people who were

1 incarcerated, released and subsequently died, the
2 majority died of an overdose," is that limited to
3 some scope of time, some period of time?

4 A. So we did the report looking one year
5 before, people died, so one year prior to their
6 death. So I believe to the best of my
7 recollection, that the majority would have been --
8 around 56 percent of those died within a year of
9 their release because of overdose, but I believe
10 about 27 percent actually died within a month of
11 release because of an overdose.

12 But that's my best recollection at the
13 time.

14 Q. And does -- in terms of years that this
15 covers, do you have any sense of whether this
16 applies just to 2015 or some other time period?

17 A. So the report covered all the deaths in
18 2016, and we would look at their life one year -
19 that's 12 months - prior to their death. So if
20 someone died on March 31st of 2016, we would have
21 gone back till March 31st of 2015. If someone died
22 on November 11th of 2016, we would have gone back
23 to November 11th of 2015.

24 So for every individual as I mentioned

1 before, it was a CSI type of examination, very
2 labor-intensive, to look at their life, their
3 interactions in the 12 months prior to their death,
4 and that's the way I would explain it.

5 Q. So just to be clear, does it refer to
6 people who were both released and died in that time
7 period?

8 A. Yes.

9 Q. So of all the people who were released
10 during the time period, what percentage also died
11 in the time period?

12 A. So once again, my recollection is that
13 people who are released within 12 months, 56
14 percent of those people who died within 12 months
15 of their release died because of an overdose.

16 I would really want to look at the
17 report to make sure what I'm stating is factual,
18 but that's the best of my recollection four years
19 after the release of the report.

20 Q. And again, this is a statement of fact,
21 correct? This is either something that -- this is
22 something that was derived from existing factual
23 information that was kept.

24 A. The statement that I make today sitting

1 here is to the best of my ability to recollect the
2 facts that happened four years ago in the report.

3 Q. Do you know who compiled the information
4 that went into this fact?

5 A. So as I mentioned before, there were
6 multiple partners and agencies across the country
7 that included within West Virginia, Department of
8 Military Affairs and Public Safety, Department of
9 Medicaid, Emergency Medical Services, behavioral
10 health systems and behavioral treatment programs,
11 Medical Examiner's Office, the Centers for Disease
12 Control and Prevention, to provide the technical
13 expertise. And there may be some others.

14 But all of that you can find in the
15 report itself.

16 Q. So your information -- what you are
17 relating to me is essentially secondhand
18 information. Correct, Doctor Gupta?

19 MS. KEARSE: Objection.

20 A. I'm not sure what you mean by that.

21 Q. Well, you didn't compile this information.
22 We agreed on that earlier, right?

23 A. I was the Commissioner who commissioned the
24 report and oversaw every aspect of this report as

1 the supervisor for this report.

2 Q. Okay. Did you personally compile the
3 information that went into this particular fact,
4 Fact 14 that we've been focused on?

5 A. This report was conducted under my
6 direction.

7 Q. Okay. That wasn't my question. Did you
8 personally compile and review the information that
9 went into Fact 14?

10 A. I was not one of the people that personally
11 was compiling, because that's not the role of the
12 Commissioner.

13 Q. Do you recall, sitting here today, who that
14 person or persons would have been who compiled the
15 information?

16 A. I think it was page 3 we just went over.
17 So you may want to pull that back up.

18 Q. Would it have been somebody on that page,
19 do you think? If we showed you that page --

20 A. Yes.

21 Q. -- would you remember who it was?

22 A. Which report are you talking about
23 compiling?

24 Q. Well, I'm talking about compiling Fact 14.

1 You told me it was from the 2016 West Virginia --

2 A. Yes.

3 Q. -- Overdose Fatality Analysis.

4 A. Yes, Ms. Mainigi, I just want to make sure
5 you understand this real well, because I'm seeing
6 some signs you're not getting this part, so I
7 apologize for that, because it must be me.

8 This report was a comprehensive
9 analysis of a state-wide effort including multiple
10 agencies in a multi-disciplinary way, so it's not a
11 clerk sitting somewhere in an office with a laptop
12 compiling.

13 It's a team of experts as you see on
14 television that are constantly working together,
15 understanding, analyzing, interpreting data and
16 then putting a report together.

17 So it's a very dynamic work that took
18 several months to put together so this is not --
19 you don't put a finger on somebody and say, "Ah-ha,
20 that's the person." It's a -- it's a -- it was
21 such a unique report that several states and
22 jurisdictions since have replicated this work.

23 Q. So I take your answer to mean that it would
24 not necessarily be possible sitting here today to

1 identify the particular person or persons who
2 compiled particularly Fact 14.

3 A. And I am responding to you by saying,
4 "Please look at page 3" and all those individuals
5 have been an integral part of compiling the report
6 that's bulleted on No. 14.

7 Q. Now, this Fact 14, that's not a statement
8 that's specific to Cabell County, correct?

9 A. That statement includes Cabell County.

10 Q. It's a state-wide number, correct?

11 A. And Cabell County is part of state of West
12 Virginia.

13 Q. Okay. And you didn't break out this number
14 by state or city, correct?

15 A. We did have it by state. It was the state
16 of West Virginia.

17 Q. I'm sorry. I may have misspoken. You
18 didn't break out this number by county or city, did
19 you?

20 A. We did not -- you're -- this report was not
21 meant to be a county-by-county-by-county or
22 city-by-city report. We do have other reports. If
23 you'd like to see, we're happy to share with you.
24 But that was not the purpose of this particular

1 report.

2 Q. Did you do -- do you recall a report off
3 the top of your head, Doctor Gupta, that was
4 specific to either Cabell County or Huntington
5 city?

6 A. Yes.

7 Q. What was the report?

8 A. There was historical overview of overdoses
9 from 2000 to 2015. It might have been 2001 to
10 2015. I'm sure you'll question that. So there --
11 when I came in, one of the first things I did was
12 order that report.

13 Again, I commissioned it, a report,
14 supervisors directed it, and it ended up being a
15 historical first-time overview of the deaths that
16 were determined and distinguished by gender, by
17 county and all other factors.

18 I also did a very similar report,
19 ordered/commissioned a report on HIV profiles
20 across the state by county.

21 I also commissioned a report on
22 Hepatitis for the last several years across the
23 state.

24 I also did a report or commissioned a

1 report on neonatal abstinence syndrome across the
2 prevalence of which -- across the state, that
3 included Cabell County.

4 I did a specific report on the
5 overdoses that happened where in five hours, we had
6 over 28 people be overdosed, which became
7 nationally known in Cabell County. We conducted a
8 report with CDC and with Bureau of Public Health,
9 with Cabell-Huntington Health Department, to
10 conduct that as well.

11 As well as the HIV report we've
12 already discussed.

13 Q. With respect to the 2000 to 2015 report,
14 are you telling me that the information in that
15 report is broken down either by county or city?

16 A. Yes.

17 Q. Thank you. Coming back to this statement,
18 this Fact 14, with respect to the overdose, do you
19 know whether the overdose death was caused by
20 opioids, prescription opioids, or some other drug?

21 A. Which -- which -- the totality of deaths?

22 Q. Well, I'm just looking at the Statement 14
23 where it says, "the majority died of an overdose."
24 Do you see the word "overdose"?

1 A. Yes.

2 Q. Okay. So with respect to that word
3 "overdose," was the overdose caused -- the overdose
4 which led to the death, was that caused by
5 prescription opioids or a combination perhaps of
6 prescription opioids -- some died of prescription
7 opioids, some died of heroin, some died of
8 fentanyl, some died of something else altogether?

9 A. To the best of my recollection, in this
10 report, the overwhelming over -- drug overdose
11 deaths were -- involved opioids. They could
12 involve other substances too, but they
13 overwhelmingly involved opioids.

14 Q. What about prescription opioids?

15 A. That's included, as you stated, in the
16 overall category of opioids.

17 Q. Okay. And did you break that down? Did
18 you -- as part of your autopsy, did you figure out
19 the specific cause of death?

20 A. So Ms. Mainigi, when someone dies and you
21 have to conduct an autopsy and you look at the
22 substances in their body, the breakdown product of
23 an opioid - whether it's from heroin or from Lortab
24 or Vicodin - is no different. So you literally

1 cannot break down from the product, because they
2 are all opioids.

3 Q. I'm going to go to your Statement No. 15,
4 Doctor Gupta, next. Why don't you take a moment
5 and read it.

6 A. Sure.

7 MR. COLANTONIO: Just to be clear,
8 these aren't his statements. This is -- these are
9 something written by somebody else.

10 MS. MAINIGI: I believe they're citing
11 his deposition from last time. But thank you for
12 that. Thank you for that speaking clarification.

13 Q. Let me know when you're done with it --

14 A. I'm done.

15 Q. -- Doctor Gupta. Okay. 15, for the
16 record, says, "In 2016, it was found that those
17 overdose decedents who went to three or more
18 pharmacies to fill prescriptions were 70 times more
19 likely to have died."

20 Do you agree with this statement?

21 A. I would love to see the report and the
22 facts for themselves. But to the best of my
23 recollection, it seems accurate.

24 Q. And so by your statement, I take it you

1 believe that this is another one of the facts
2 derived from one of the reports you commissioned?
3 Is that fair?

4 A. This was also the social autopsy, same
5 report that we've been discussing.

6 Q. The 2016 report, Doctor Gupta?

7 A. Correct.

8 Q. Does this refer to people who went to three
9 or more pharmacies to fill opioid prescriptions or
10 any kind of prescription?

11 A. This goes back to, again, we interrogated
12 the Controlled Substances Monitoring Program, which
13 is the prescription drug monitoring program for the
14 State of West Virginia. That means these
15 controlled substances generally for category --
16 scheduled substances for Category II through IV,
17 and this inclusion would mean filling of
18 prescriptions from Schedule II to Schedule IV.

19 Q. Schedule II, Schedule III and Schedule IV,
20 correct?

21 A. Yes.

22 Q. Okay. Oxy and hydro, what schedule are
23 those?

24 A. They would -- well, it depends. What year

1 are you talking about for hydrocodone?

2 Q. The year the report was -- I'm sorry, I'm
3 asking about the year the report covered.

4 A. OxyContin -- oxy of any type would be
5 Schedule II, and you know, it depends on the
6 hydrocodone product. Some were Schedule III and
7 some were Schedule II at that time.

8 Q. And this report counted Schedule II,
9 Schedule III and what was contained in the Schedule
10 IV category, correct?

11 A. Correct.

12 Q. Now, this statement doesn't indicate that
13 the prescription itself that they filled caused the
14 death. Right?

15 A. It does not.

16 Q. And this statement doesn't refer
17 specifically to Cabell, correct?

18 A. Cabell's prescriptions and pharmacies would
19 be -- and people that live in Cabell, were included
20 in the analysis of this report.

21 Q. You can't break out the numbers for Cabell,
22 can you?

23 A. You can. We just didn't do it. But you
24 can.

1 Q. And how about for Huntington? Did you
2 break out the numbers for Huntington?

3 A. We did not. But you can.

4 Q. And this refers to people who went to three
5 or more pharmacies in 2016 or 2015?

6 A. This would be, once again, 12 months prior
7 to their time of death in 2016.

8 Q. Okay. Now, this statement is also a fact,
9 correct?

10 A. Once again, to the best of my recollection
11 - without having the report in front of me - from
12 four years ago, I believe that is -- this seems
13 accurate, but I cannot attest to it at this time.

14 Q. Okay. And in terms of how this information
15 was compiled, the information was compiled and put
16 together by presumably the same set of individuals
17 that were on page 3, correct, of the report?

18 A. Right.

19 Q. Okay. I'm going to move on to Statement
20 16, Doctor Gupta, if you could take a moment and
21 read that.

22 A. I'm done.

23 Q. The statement says, "Three out of the four
24 people that died of an overdose in 2016 tried to

1 seek help within the year before their time of
2 death." Is that a statement you agree with?

3 A. To the best of my recollection. I thought
4 it was more like 80 percent, four out of five, but
5 it could be either three out of four or four out of
6 five. But a high number of people had come in the
7 system, interacted with the health care system, in
8 the 12 months prior to their death.

9 Q. And this, you would agree, is a statement
10 of fact.

11 A. I would say that -- to my response in the
12 previous question, that -- the response would be
13 similar to that.

14 Q. Okay. And I'm sorry, Doctor Gupta, but I
15 -- let me state that so that your answer is not
16 unclear. By that, you mean it -- this fact, that
17 is No. 16, is derived from one of the two reports
18 that we've been discussing? Is that fair?

19 A. I cannot be certain of that.

20 Q. Do you know what the derivation is of this
21 fact?

22 A. I'm sorry? Can you repeat?

23 Q. Do you know what the derivation is of this
24 fact? Where did this fact come from?

1 A. As I stated previously, in the social
2 autopsy report, to the best of my recollection, we
3 saw close to 80 percent of the people that had died
4 of an overdose in 2016 had tried to seek help from
5 the health care system within the 12 months prior
6 to their time of death.

7 And so while my recollection doesn't
8 align with this statement exactly, that may be the
9 source of the statement.

10 Q. Do you remember whether before you gave
11 your deposition in September, did you read the
12 autopsy report before you went in to your
13 deposition?

14 A. I don't remember.

15 Q. Okay. In terms of who would have -- if in
16 fact this is a statement from one of the two
17 reports, the 2016 report or the '01 to '15 report,
18 the information would have been compiled by the
19 group of people that are on page 3? Is that fair?

20 A. That would be accurate.

21 Q. You didn't compile this information
22 yourself, correct?

23 A. I oversaw, directed and commissioned the
24 report as the Commissioner of Health of the State

1 of West Virginia, and obviously I approved the
2 report to be published.

3 Q. The phrase "tried to seek help," what does
4 that mean to you?

5 A. What that means is, from the report, what
6 we found was that these individuals in the 12
7 months prior to their death from drug overdose had
8 either visited an emergency room or had called an
9 EMS or had seen somebody at behavioral health, but
10 there were some interaction of them with the health
11 care system.

12 Q. Do you have an impression or understanding
13 of where the information came from for this fact?

14 A. As I stated prior, that the multi-agency,
15 multi-disciplinary work that it took to put the
16 social autopsy 2016 report together that I
17 commissioned, oversaw, directed and managed and
18 approved allowed various agencies across the State
19 to work together to create this.

20 So information like this or similar to
21 this in some form or shape would have come out from
22 the work of the multi-agency within the State of
23 West Virginia.

24 Q. But specifically, you don't know what set

1 of data or information was searched to get to this
2 fact. Do you?

3 A. I just told you - I'll repeat it again -
4 that the multi-agencies that were involved included
5 EMS; they included state Medicaid agency; they
6 included behavioral health providers; they included
7 medical examiners; they included, you know,
8 Controlled Substances Monitoring Program; Board of
9 Pharmacy and some others.

10 And that's where this information from
11 their database would be coming from.

12 MS. MAINIGI: I think now would be a
13 good time for another short break. How's ten
14 minutes, Doctor Gupta, for us to take a break?

15 THE DEPONENT: That would be great.

16 MS. MAINIGI: Okay. Thank you. We'll
17 be back in ten minutes.

18 VIDEO OPERATOR: Going off the record.
19 The time is 2:16 p.m.

20 (A recess was taken after which the
21 proceedings continued as follows:)

22 VIDEO OPERATOR: Now begins Media Unit
23 3 in the deposition of Rahul Gupta, M.D. We're
24 back on the record. The time is 2:31 p.m.

1 BY MS. MAINIGI:

2 Q. Doctor Gupta, I'm going to show you
3 Statement No. 3, Bullet No. 3 of Exhibit 58.

4 MS. MAINIGI: Steve, could we scroll
5 down to it, please?

6 MR. RUBY: Yep. There's a little lag
7 here. Sorry.

8 MS. MAINIGI: Sorry.

9 Q. Okay. Doctor Gupta, why don't you take a
10 moment and read that? Let me know when you're
11 ready.

12 A. Okay.

13 Q. Okay. Statement 3 reads, "There is a
14 direct correlation between diverted prescription
15 pills and the transition to using street drugs such
16 as heroin, fentanyl, methamphetamine, etc." Do you
17 agree with this statement, Doctor Gupta?

18 A. Yes.

19 Q. And what is your basis for this statement?

20 A. Well, it's both the literature that exists
21 to support that as well as my experience and the
22 opinions that have resulted from my experience.

23 Q. Okay. Can you give me specific literature
24 references that would support that statement,

1 Statement 3?

2 A. Sure. You know, as -- I think back as
3 2014, Theo Cicero actually published a 50-year
4 analyses in general psychiatry that showed that,
5 you know, as much as 75 to 80 percent of the
6 transition that was happening in people who were
7 using heroin was actually -- they were the people
8 that were in fact looking at -- nowadays, were
9 transitioning from prescription drugs, as opposed
10 to the '60s where 80 percent of people were going
11 in the opposite direction.

12 So there's been a lot more literature
13 since that that shows about 80 percent of the
14 people that use heroin today have had their start
15 from prescription opioids to begin with.

16 Now, having said that, we saw very
17 similar facts in West Virginia. We started to see
18 people that were often - because of a large volume
19 and diversion that resulted often in addiction were
20 utilizing prescription drugs, and as there was more
21 policy and actions that were being taken to address
22 that - part of that was reduction in supply - these
23 people really often, as an example, when there was
24 action on shutting down a pill mill, there were

1 often people that would then not have a supply.

2 As a result of that, they would either
3 have two or three options. One option was to go to
4 the emergency room. We saw flooding of the
5 emergency room.

6 Second was to go to street drugs which
7 were much more readily available, cheap in terms of
8 heroin, or just die, overdose and die.

9 And we were seeing all of this. So
10 our findings matched what was being published. In
11 fact, there's been some work done by Sarah Mars in
12 Philly population that also showed very similar
13 numbers, and we were matching that up.

14 So as that began to happen, more and
15 more people transitioned to heroin, there began an
16 infiltration of cutting heroin with fentanyl by
17 drug dealers primarily to save costs, to make more
18 money.

19 And as that was happening, fentanyl,
20 of course, is a substance that's about 80 times
21 more potent than morphine, so because it was
22 uncontrolled, we were seeing batches of deaths
23 happening together because of bad batch of
24 fentanyl-cut heroin.

1 Across West Virginia, that was the
2 case. When we had in 2016, fall of 2016 or so, an
3 outbreak in Huntington, West Virginia that was
4 first but not the only of its kind across the
5 country, where in a matter of hours, dozens of
6 people were overdosed and had to be taken to the
7 hospital.

8 This was an example of where disease
9 from overdose was starting to simulate an
10 infectious disease, meaning you have a patient zero
11 and -- or -- which would actually be a drug dealer
12 that would have a bad batch, and that many people
13 would get impacted.

14 Same thing happened in Beckley during
15 my tenure, and other places as well.

16 So that -- that first phase was
17 prescription drugs. The second phase, because of
18 increased volume -- the volume, diversion and
19 addiction was actually getting it on.

20 And the action that followed was to
21 transition to heroin. That was wave two, as CDC
22 describes it.

23 The third wave was actually mixing of
24 heroin with synthetic opioids like fentanyl, and I

1 truly believe we're in the fourth wave. The fourth
2 wave now, in the last few years, has been that
3 there's a trend now to utilize not just a -- one
4 type of medication, but also a combination of
5 medications.

6 So now, the same population described
7 as (Zoom audio glitch) is transitioning to
8 polysubstance use, meaning oftentimes we're finding
9 now the pills have not just meth, but also fentanyl
10 in it. And the combination of people using heroin,
11 fentanyl, and methamphetamine and cocaine, that
12 means stimulants and depressants at the same time,
13 is -- is, you know -- is evolving at this point.

14 And there's been data that has shown
15 -- for example, Chris Jones at CDC, has evaluated
16 data published from 2015 to 2018 data that looked
17 at, and 40 percent of those people who used meth,
18 crystal meth, in the past year utilized
19 prescription drugs, prescription pills,
20 prescription opioids.

21 So that's been important. And we also
22 know through some of the work with Beth Han at JAMA
23 Psychiatry that was also published that showed the
24 overdose death rate has now gone five times, five

1 full increase, because of meth.

2 So we're seeing a lot more carnage on
3 the streets, certainly in Cabell County,
4 Huntington, West Virginia, not very dissimilar than
5 other parts of the country, where we are seeing
6 this transition of prescription pills to drugs like
7 heroin, fentanyl and now meth and cocaine.

8 And one of the problems we're seeing
9 also as a result of that is because when we went
10 from pills to IV drug use, which is heroin and
11 fentanyl and often sometimes meth as well, we're
12 seeing the increased risk of communicable diseases
13 such as HIV and hepatitis.

14 So that's one of the reasons we've
15 had outbreaks of HIV in West Virginia and other
16 parts of the country as well, because of increased
17 use of needles and syringes that ultimately
18 emanates from the prescription pill volume.

19 Q. Okay. Let me stop you, Doctor Gupta, then
20 and dissect some of what you've said at least. You
21 mentioned JAMA Psychiatry -- was there a specific
22 -- I missed the very first thing you said. Was
23 there a specific study from JAMA Psychiatry that
24 you referred to? That's the only question on the

1 table right now.

2 A. The first study I mentioned was from Theo
3 Cicero in JAMA Psychiatry in 2014.

4 Q. Okay. Thank you. Your experiences in West
5 Virginia, did you document those experiences
6 anywhere?

7 A. I'm not -- I'm not sure what you mean. You
8 can see -- I guess --

9 Q. You told me about your experience, right,
10 in West Virginia? And I don't need that recapped.
11 I heard it. Did you document that in your own
12 study or paper, for example?

13 A. I -- as Commissioner, I would have provided
14 interviews to media outlets, and you're welcome to
15 search the databases to review my views, my
16 opinions and my experiences in the public domain.

17 Q. Okay. You mentioned Sarah Mars who
18 described the Philly population. Do you recall
19 doing that?

20 A. Yes.

21 Q. I take it that Ms. Mars documented
22 somewhere some sort of study related to the Philly
23 population. Is that right?

24 A. As a researcher, yes.

1 Q. Okay. When you designed the first phase,
2 which is the phase related to prescription opioids,
3 what's that general time period that you're
4 defining that first phase?

5 A. The general time period would have been
6 from the beginning of 2000s to about 2010 or so.

7 Q. Okay. And then the second phase, which is
8 the move to -- is the move to meth and heroin and
9 other illegal substances; is that fair?

10 A. No. Actually, the second phase is actually
11 when we transitioned to heroin, which would have
12 been mostly around the time from about 2011 to
13 2015, with, of course, significant overlaps,
14 because one doesn't purely transition to the other,
15 but there would be overlaps, because 2010, '11, as
16 we began to enact policies, programs and regulatory
17 actions that would help us downstream reduce the
18 volume of pills, there was transition happening
19 into the street alternative, which is (audio
20 glitch).

21 Q. And then the third phrase you define is
22 what period of time, approximately?

23 A. So that would be roughly from 2015 onwards
24 when not only it was just heroin and prescription

1 pills that was ongoing, but the addition of heroin
2 being cut with fentanyl.

3 Q. The -- coming back to your experiences,
4 just to confirm, I'm not aware of any statistical
5 analysis or sampling that you did with respect to
6 this Statement No. 3 that we're talking about.
7 True?

8 A. The reports are there, Ms. Mainigi, for you
9 to look at. I'd be happy to share with you all of
10 the data. But it is also my opinion that this was
11 happening. So we have the reports, and we have my
12 opinion.

13 Q. Okay. And the reports that we're talking
14 about primarily are the two reports that we've
15 spoken about, the autopsy report from 2016 and then
16 the 2000 to '15 report?

17 A. They wouldn't be the only reports. They
18 would be helpful, but during my time as
19 Commissioner, we provided to the public very
20 regular reports of all overdose deaths and the
21 trends and analyses that happened and that were
22 happening across the state, including in Cabell
23 County, including in the City of Huntington.

24 We were providing those pretty

1 frequently and regularly to the public. I would
2 encourage you to look at those as well.

3 Q. Okay. Well, tell me where I can find the
4 specific data relating to Cabell and Huntington as
5 it relates to Statement No. 3 that we've been
6 discussing.

7 A. Well, the easiest way for you to be -- go
8 ahead and FOIA those documents in the State of West
9 Virginia, and you'll find them.

10 Q. Okay. And what would I FOIA, Doctor Gupta?

11 A. You would FOIA as we just mentioned: The
12 reports, trend analyses, the cause of overdose
13 deaths based on counties across the state.

14 Q. Your statement here notes the correlation
15 between diverted prescription opioids and then the
16 transition to the use of illegal substances. Your
17 use of the word "diverted," is that the same
18 definition of diversion that you gave me earlier in
19 your testimony?

20 A. When I speak about "diverted," what I
21 really mean, that as we saw the SAMHSA National
22 Survey of Drug Users Health Survey in 2017, about
23 two-thirds of the pills that were there,
24 prescription pills, prescription opioids that were

1 coming from friends and family, and only about -- I
2 want to say about maybe 5 percent or so that we
3 collect or being sold or something like that.

4 So about -- it was a rule of thirds.
5 Two-thirds were being diverted from prescriptions
6 from friends, family, neighbors and others; and one
7 third of those were being prescribed appropriately
8 but misused in some way or another.

9 So I would say that it's the
10 legitimate prescriptions as well as illegitimate
11 prescriptions, and of course, those -- both of
12 those, as we know now, used beyond a period of time
13 they're recommended lead to addiction.

14 And of course, when we say "transition
15 to street drugs," that means those individuals that
16 are suffering from substance use disorder as a
17 consequence of using prescription pills that are
18 now having to seek alternatives to continue the,
19 you know, managing their disease through street
20 drugs, and that's what I mean.

21 Q. So the two-thirds, the SAMHSA study that
22 you reference, the diversion that occurs related to
23 friends and family occurs after the prescription
24 bottle has come home, perhaps been somewhat used,

1 but you've got leftover pills presumably lying
2 around. Fair?

3 A. The two-thirds approximately on the survey
4 that was reported was often -- were prescriptions,
5 prescription drugs - so we're only talking about
6 the prescription drugs at this point - that people
7 have brought home.

8 Now, these could be legitimate
9 prescriptions; they could be illegitimate
10 prescriptions.

11 And -- but if those that are flooding
12 the population because of the large volume that
13 happens. So someone had a -- you know, I use a
14 tooth pulled example. But you could use a cataract
15 example, but something for a one-time event but
16 somebody got 30 days with three refills, well,
17 that's going to lay around and that's going to get
18 into the hand of children -- hands of children or
19 somebody else, for all types of purposes, and
20 that's the diversion.

21 Now, on the other hand, when somebody
22 gets it for a legitimate prescription and also
23 either goes and sells it or misuses it or gives it
24 to somebody else to misuse, that's also diversion.

1 So -- and then obviously diversion
2 leads to addiction which leads to the constant need
3 to have some sort of opioids in your system that
4 when those volumes start to shrink, people
5 transition to other types of alternatives.

6 Q. Now, you are aware, Doctor Gupta, are you
7 not, that the vast majority of people who use
8 prescription opioids do not become addicted to
9 street drugs?

10 A. I'm sorry, could you repeat that, please?

11 Q. Sure. Do you agree that studies
12 demonstrate that the vast majority of people who
13 use prescription opioids do not become addicted to
14 street drugs?

15 A. We're talking about two very different
16 populations, so I'm not sure of the correlation.
17 Are you talking about -- I need to have more data
18 on that.

19 Q. Okay. In your experience then, as a
20 practicing physician as well as the various roles
21 you've held in West Virginia, do you agree that the
22 vast majority of people who use prescription
23 opioids do not become addicted to street drugs?

24 A. What time frame are we talking about? I'd

1 like to -- you know, like I said, I'd like to know
2 more about that.

3 Q. The time frame that you held the positions
4 in West Virginia that we've been discussing.

5 A. That's not what I'm asking you. I'm asking
6 what -- for what duration of prescription opioids
7 do those people use, and for what purpose? Because
8 context is important.

9 Q. During the -- the vast majority -- do most
10 people use prescription opioids for long-term
11 periods?

12 A. So in 2012, United States, we had
13 255,000,000 prescriptions. That was 80
14 prescriptions for 100 people across the country. I
15 hope that answers my question -- your question.

16 Q. Well, why don't we -- so you don't have --
17 I'll just ask you one more time. You -- from your
18 experience, you don't have an opinion on whether
19 the following statement is true or false. The --
20 and the statement is: "The vast majority of people
21 who use prescription opioids do not become addicted
22 to street drugs."

23 A. According to the 2016 March guidelines for
24 chronic pain from the Centers for Disease Control

1 and Prevention, use of prescription drugs, opioid
2 prescriptions, for more than five or seven days,
3 puts you at a very high risk for addiction.

4 Q. For addiction to that prescription drug,
5 correct?

6 A. For addiction -- for the disease of
7 addiction. Period.

8 Q. Let's go to Statement 4. Why don't you
9 take a moment and read it.

10 A. Okay.

11 Q. Okay. Statement says, "Once an addiction
12 is formed, an individual struggling with addiction
13 will obtain the addictive substance by any means
14 necessary, which often results in illegal activity
15 and the use of illegal substances."

16 Do you agree with that statement?

17 A. Here's what my opinion is: I believe that
18 once someone is suffering from substance use
19 disorder, that individual is struggling with a
20 disease, is -- has a actual chronic relapsing
21 disease, and it becomes then very important that
22 that individual is offered the help in order to
23 treat that disease, just like we would do for
24 diabetes or cancer or anything else.

1 Going untreated, there are a number of
2 risks to that individual that include all the way
3 from -- from suffering from disease, other mental
4 health conditions, to all the way to death.

5 Q. Doctor Gupta, I'm going to explore some of
6 what you just told me in a minute. But before we
7 do that, can I just ask you to look at statement --
8 the statement that's marked 4 and tell me whether,
9 as written, whether you agree with it or disagree
10 with it.

11 A. I'm not sure I have an opinion about that
12 statement, the way it's written.

13 Q. Do you know what percentage of people
14 struggling with addiction do illegal things to
15 support their addiction?

16 A. I don't have a percentage at this time.

17 Q. Do you know what percentage of people who
18 become addicted to prescription opioids go on to
19 use other illegal substances?

20 A. From the data that I've highlighted prior,
21 it's -- what we know now is about 80 percent of
22 people who are using heroin got their start from
23 using prescription opioids.

24 Q. That is not the question I asked. Right?

1 A. That is the answer.

2 Q. What percentage -- I'm sorry?

3 A. That is exactly the answer I provided,
4 so --

5 Q. That's the only figure that you have then.
6 Fair?

7 A. Well, I'm happy to rephrase it if you have
8 -- you know --

9 Q. Well, let me ask you the question again,
10 just in case I misunderstood your answer. Can you
11 tell me what percentage of people who become
12 addicted to prescription opioids go on to use other
13 illegal substances?

14 So this is the percentage of people
15 who become addicted to prescription opioids.

16 A. So to my previous statement, I think by
17 phrasing the question the way you have, you're
18 discounting the thousands of West Virginians and
19 hundreds of thousands of Americans who have
20 actually perished as a result of addiction, and I
21 think it's an unfair question to ask that way.

22 Q. Okay. I will take from your answer that
23 you don't have a number, Doctor Gupta. Let me move
24 on to your Statement No. 5, if I could. Let's move

1 that up here so we can see it.

2 Statement 5 reads, "The IV drug use
3 problem in Cabell County and the City of Huntington
4 is an evolution of the prescription drug problem."
5 Do you agree with that statement?

6 A. I would say broadly, yes.

7 Q. And you're not a specialist in IV drug
8 addiction, correct?

9 A. I'm an internist, as we made clear, with
10 public health expertise as well as in a number of
11 areas, so I'm not sure what you're referring to, if
12 that specialty exists.

13 Q. Did you do any sampling for statistical
14 analysis as it relates to Statement No. 5 in Cabell
15 County?

16 A. Once again, I would refer you to state, to
17 county -- county analysis we have for both the
18 prevalence of disease as well as others that we
19 regularly provide in the analysis.

20 You might find that, actually, some
21 version of that in the 2015 report.

22 Q. Okay. Sitting here right now, are you
23 aware of a specific analysis in Cabell County that
24 correlated the use of prescription drugs and then

1 subsequent IV drug use?

2 A. I would love to take a peek, but you won't
3 let me, into these reports. So I'm handicapped in
4 the way I'm answering my question -- your
5 questions.

6 Q. Okay. But sitting here right now, no
7 specific report that you commissioned is coming to
8 mind, Doctor Gupta, that would allow me to see that
9 correlation?

10 A. Ms. Mainigi, I mentioned there is a report,
11 but you're not going to let me see it, so what's
12 the point?

13 Q. Which report?

14 A. The 2000 to 2015 analyses.

15 Q. Okay. I will see if I can look at that on
16 the next break. But we are time limited here, so
17 that's -- that's part of our problem. But you
18 think if there's an answer, it would be in the 2000
19 to 2015 analyses.

20 A. That would be one of the areas to go into.
21 And I've given you a number of other potential ways
22 and means to get there if you wish to.

23 Q. Now, when you use the word "an evolution"
24 in this statement, No. 5, are you referring back to

1 the different phases that you went through with me,
2 the fact that you think Phase 1 is prescription
3 opioids and then that went to heroin as Phase 2 and
4 then a subsequent Phase 3 and Phase 4?

5 A. Yeah, basically the recognition that, you
6 know, the prescription drug was a sentinel event,
7 the volume, that has led to such the complexity and
8 evolution of the problem in a way that now we're
9 almost circling back to where we're finding more
10 and more prescription drug supply that is being
11 contaminated with fentanyl, in fact.

12 So it started from pills; it's now
13 coming back to pills in some areas of the country.

14 Q. Now, it's not the case, is it, that all use
15 of IV drugs is caused by prescription opioids?

16 A. Yeah, so in the data I mentioned -- which
17 is, again, broadly agreed by all the experts. I
18 don't know if there's any IV drug use experts in
19 the nation, but clearly the experts that I work
20 with as an expert with those across the nation, it
21 is very broadly agreed that about 80 percent of the
22 heroin users have started their -- with
23 prescription drugs.

24 That would, of course, leave the 20

1 percent that may have had different reasons or
2 other reasons to do that. So that just does leave
3 that 80/20 rule to -- to consider.

4 Q. And I think the number -- but I don't want
5 to go round and round with you on it. The number
6 I'm saying is -- is it -- so do you think 80
7 percent of IV drugs -- drug use is caused by
8 prescription opioids?

9 A. The evidence suggests that, you know, 8 out
10 of 10 people who are using heroin right now. And
11 my opinion to a reasonable degree of certainty is
12 based on that for Cabell County from the -- for the
13 City of Huntington and for the State of West
14 Virginia.

15 Q. Okay. And 8 out of 10 -- your opinion is
16 that 8 out of 10 Cabell County heroin users what?
17 Finish out your opinion.

18 A. Began their journey to developing addiction
19 - substance use disorder, in other words - from --
20 and got initiated from prescription opioids.

21 Q. And by "prescription opioids," you include
22 in that prescription opioids that they may have
23 diverted from someone else. Right?

24 A. Yeah, so we include legitimate prescribing;

1 we include illegitimate prescribing; we include
2 diverted in the sense of borrowing, stealing,
3 purchasing, all of those things.

4 Q. Have you done any independent analysis -
5 besides relying on this study that you referenced -
6 to determine if this 80 percent number is
7 applicable to Cabell County?

8 A. As I've stated, that's my opinion to a
9 reasonable degree of certainty.

10 Q. And my question is: Have you done any
11 independent research to determine if that 80
12 percent number is applicable to Cabell County?

13 A. I can't recollect at the time, so I can't
14 say yes or no. I just don't -- I don't remember at
15 this point.

16 Q. And do you remember whether you did any
17 independent research in the City of Huntington to
18 determine if that 80 percent number is applicable
19 to the City of Huntington?

20 A. No, I don't think I -- I can't recollect.
21 But also, you know, we have 55 counties in the
22 state, first of all. Second, there was an outbreak
23 of overdose, and I can't recollect at this time the
24 exact findings of the outbreak in 2016.

1 So that's another resource for you to
2 go and look at if you -- if you're willing to.

3 Q. By the way, the 80 percent number that you
4 cite, what study does that come from?

5 A. That's -- a number of people have done
6 that. So the Theo Cicero, as I mentioned, JAMA
7 Psychiatry. It's something that has generally been
8 accepted. You know, I can help -- I can provide
9 you the specific resources. But Theo Cicero found,
10 I think, about 75 percent.

11 And I think most -- most of the data
12 has usually quoted 80 percent.

13 Q. But you recall -- the one you're
14 specifically recalling is Cicero.

15 A. Yeah. Cicero had 75; I think Sarah Mars
16 may have 80. But that's an agreed-upon -- and I
17 want to say with a reasonable degree of certainty
18 that CDC utilizes that number as well.

19 Q. The CDC uses that number as well. Okay.

20 A. Yeah. I -- I want to say -- again, I'd
21 have to -- if I was allowed to look at it, I would
22 look at the stats. But you know, we're not in that
23 phase right now.

24 Q. And what stats would you be looking at

1 besides the ones you've mentioned, Doctor Gupta?

2 A. I would be confirming my statements that
3 CDC numbers --

4 Q. Let's shift to Statement 11, if we could.
5 Why don't you take a moment and read that.

6 MR. RUBY: This spans two pages,
7 Doctor, so let me know when you're ready to --

8 THE DEPONENT: Okay. Go ahead,
9 please.

10 MS. MAINIGI: Steve, there's no way to
11 get both pieces in?

12 MR. RUBY: Let's see. We might be
13 able to shrink it. There we go.

14 MS. MAINIGI: There we go. You're
15 such a pro, Steve.

16 BY MS. MAINIGI:

17 Q. Okay, Doctor Gupta, Statement 11 reads as
18 follows: "Although there was a 15-20% reduction in
19 opioid prescriptions in 2015 and 2016, there was no
20 reduction in overdose deaths because the addiction
21 had already been formed and people with opioid use
22 disorder were turning to illicit, more lethal forms
23 to feed their addictions that was initially formed
24 by prescription opioids."

1 Do you agree with that statement?

2 A. I would generally agree. I think the
3 change in West Virginia was about 15 percent
4 reduction in opioid prescriptions from 2015 to '16.
5 So with that exception to more like 15 percent, I
6 would agree with that.

7 Q. Okay. And the 15 percent reduction, I'm
8 assuming that's something that is a statement of
9 fact that's checkable, correct?

10 A. Yeah. In fact, it's not only a statement.
11 This was the largest reduction in the country of
12 any state. So West Virginia, while I was the
13 Commissioner, not only declined its prescriptions
14 from 2015 to '16 within one year, it had the
15 largest decline of any state in the union.

16 Q. And the fact that there was no reduction in
17 overdose deaths in that same time period, that's
18 also a statement of fact, correct?

19 A. That's a statement that goes back to Phase
20 2, as we discussed. So this is -- this statement
21 is very much indicative of my opinions being formed
22 about the Wave 2, basically.

23 Q. Okay. Well, let me focus just on the
24 statement, not the correlation between those two

1 statements. The statement that there was no
2 reduction in overdose deaths in the same time
3 period, 2015 and 2016, that's a checkable fact.
4 Right?

5 A. Right.

6 Q. Okay. And I assume that -- do these
7 statements come from your autopsy -- the 2016
8 autopsy report?

9 A. Again, Ms. Mainigi, you won't let me look
10 at it. How can I tell you that?

11 Q. Now, the data that made up the 15 percent
12 and the data that made up the overdose -- no
13 reduction in overdose deaths, you didn't compile
14 any of that data yourself, correct?

15 A. As a commissioner, I, once again,
16 oversaw/directed/supervised, authorized the chief
17 medical examiner to both analyze as well as put
18 together, as well as my epidemiology team, from my
19 instructions, to look at the overdose deaths.

20 As far as the prescribing data, that
21 did not come from the Bureau for Public Health. So
22 I cannot speak to the prescription data because
23 that was not within the prerogative of the Bureau
24 for Public Health, but I can speak to the overdose

1 deaths data because I was directly in oversight of
2 that data.

3 Q. Can you tell me, Doctor Gupta, what
4 percentage of people in Cabell County in this time
5 period who were prescribed opioids later used
6 illicit drugs?

7 A. I don't have that number with me right now.

8 Q. Do you have it anywhere?

9 A. I wouldn't know. You wouldn't let me look
10 at anything.

11 Q. Well, where are the places you would go to
12 find that number, Doctor Gupta?

13 A. I would look at publicly-available data,
14 reports.

15 Q. Besides the two reports that we've spoken
16 about, what other reports would you look at?

17 A. I would look at any other public reports
18 that are available; I would again go back to and
19 ask the State of West Virginia to provide that data
20 if you so desire.

21 Q. Is that your position, Doctor Gupta, is it,
22 that everyone who's prescribed opioids later uses
23 illicit drugs?

24 A. That's absolutely not my position. In

1 fact, as I had asserted today, is the problem began
2 to evolve because when the efforts of regulators,
3 policy makers and others to -- in a downstream way,
4 to limit the volume of the pills that was coming
5 from upstream and drowning our communities,
6 including City of Huntington and Cabell County and
7 the rest of the state, we were doing what we could
8 to limit the volume. And part of that volume
9 limitation was to put in practice various
10 regulations as well as education activities as well
11 as enforcement activities.

12 The consequence, unintended
13 consequence of that when this was happening, is
14 that people were transitioning because by no fault
15 of theirs, they were suffering from what you may
16 know as addiction, we know as substance use
17 disorder.

18 And substance use disorder is actually
19 a disease. It's a chronic relapsing disease, that
20 people are the victims of the disease. As these
21 victims were suffering from a disease, they had to
22 find other sources of opioids, so they transitioned
23 on to the street alternative, as a result of which
24 they began to use IV drugs in terms of heroin and

1 ultimately would die because of overdose,
2 especially because of the surge of the cutting of
3 that heroin with fentanyl.

4 So you know, it all depends where
5 those clinics were being shut down, where more
6 physicians and other prescribers were reducing the
7 supply, meaning writing fewer prescriptions, and
8 where there were, you know, less diversion of the
9 volume.

10 That's what was happening more,
11 meaning in terms of transition to heroin and
12 fentanyl.

13 Q. What were the efforts -- just at a high
14 level, what were the efforts that were made by you
15 and your colleagues to reduce volume?

16 A. So prior to my coming into the office,
17 there were legislation that required mandatory
18 educational training in terms of CMEs for all
19 prescribers for opioids.

20 There were more regulations of the
21 CSMP, the State's PMP, to be able to interrogate
22 every time you are wanting to prescribe an opioid.

23 There was more focus on ensuring that
24 there was Good Samaritan Laws. There was more

1 available giving of naloxone. There was another
2 look being taken at medications to assist in
3 therapy, treatments and things like that.

4 When I came in, clearly we looked at
5 this number, the social autopsy that you -- you've
6 discussed today, and we really put the legislation
7 in the next year through what we called Opioid
8 Reduction Act.

9 I believe it was Senate Bill 273 in
10 the legislative session of 2018, to limit the
11 initial prescribing to about four days unless there
12 were reasons to -- not to.

13 Also in 2016, as soon as the CDC's
14 guidelines came out for chronic pain, Governor
15 Tomblin became one of the first governors in this
16 country to adopt uniformly the pain guidelines and
17 we worked very closely with our insurance providers
18 as well as our prescribers to do what they could to
19 adhere to those pain guidelines for -- or for
20 chronic pain guidelines.

21 So these are just some of the
22 efforts. We did make naloxone available, but in
23 terms of just reducing the volume, these are some
24 of the efforts that we were doing.

1 Q. And the efforts were directed to helping
2 physicians manage the standard of care for treating
3 pain which had evolved in the early aughts, fair?

4 A. Yeah, I wasn't -- yeah, I mean, we had a
5 standard of care in the 2000s and late '90s which
6 actually treated pain as a vital sign. The HCAP
7 surveys from AHRQ were still in place that -- you
8 know, that incentivized hospitals to be asking
9 those questions about pain.

10 So we were swimming upstream against
11 the wave in order to limit the volume where pain
12 was still the fifth vital sign.

13 And often incentivizing hospital care
14 to -- you know, to look at satisfaction -- patient
15 satisfaction rather than treatment of pain
16 adequately.

17 So we were working against that wave
18 to ensure that our physicians across the state
19 understood what legitimate good prescribing looked
20 like, what -- what made sense to make sure that we
21 were prescribing for legitimate pain, nothing else.

22 Q. Now, I think you described in your prior
23 deposition the reasons for the change in standard
24 of care that the doctors provided in the -- in the

1 late '90s, early aughts. One was an ethical
2 reason, the doctors had an ethical obligation to
3 reduce patients' pain down to zero. Is that fair?

4 A. I don't think I said that doctors -- I said
5 the manufacturers, you know, and others created a
6 system or an environment where physicians were made
7 to feel that there was an obligation to bring
8 everyone's pain down -- across America, down to
9 zero level.

10 And the pills that we were provided
11 should be provided liberally, and there is no
12 problem, there's no addiction, there's no side
13 effects of those pills.

14 So that was a -- that was a -- the
15 effect that was created. Purposefully, now we
16 know.

17 But -- and clearly organized medicine
18 was engaged in that.

19 Q. And so the efforts that were made in West
20 Virginia in 2015, '16, '17 were to help counter
21 balance that through the physician population.

22 A. The efforts were to educate prescribers -
23 not just physicians, all prescribers - for Schedule
24 II to ensure that they understood what good

1 practice guidelines are for pain. They understood
2 the risk of addiction, especially with longer --
3 higher doses and longer durations, and they were
4 more judicious in prescribing.

5 And for those who already were
6 suffering from substance use disorder were able to
7 seek the help that they could so they do not
8 overdose and they do not die.

9 Q. Let's switch gears to Statement 19, Doctor
10 Gupta. It's --

11 MS. MAINIGI: Let's scroll down to
12 that.

13 A. Okay.

14 Q. That statement reads, "Addiction tells
15 people to seek opioids in one form, shape or
16 other." Do you agree with that statement?

17 A. I would -- I would say it this way: It's
18 my opinion that substance use disorder makes people
19 seek substances to continue to feed the habit
20 because there's a constant need for Dopamine in
21 the -- in the brain.

22 So -- and then people would do - in
23 the grips of addiction - as a result, what they
24 need to do to continue to seek those substances.

1 Q. What is your basis for this opinion, Doctor
2 Gupta?

3 A. The basis for my opinion is my training in
4 medicine; my experience, 25 years of practice of
5 medicine; and with a reasonable degree of
6 certainty, as well as my understanding of the
7 science of addiction and substance use disorder.

8 Q. Do you have any research papers that you
9 can cite to me as support for this statement?

10 A. Sure. You can probably -- there's a PBS
11 documentary on Nova called "Addiction." They have
12 featured the director of the NIDA, National
13 Institute of Drug Abuse, a few addition -- an
14 addiction psychiatrist and myself, to talk about
15 addiction.

16 And you're welcome to see that.
17 That's kind of one aspect. But then I'm happy to
18 get you textbooks for addiction or papers or
19 otherwise. But this is the -- the science of
20 addiction, while developing and evolving, this is
21 what we understand today in medicine.

22 Q. Now, you are not an expert in addiction
23 psychiatry, correct?

24 A. That's correct.

1 Q. You're not an expert in neurobiology?

2 A. I don't know what that expertise is, as I
3 said before.

4 Q. Let me go back to one of the things -- one
5 of the statements we were discussing previously,
6 Doctor Gupta. When there was a reduction in the
7 levels of opioid prescriptions in the 2015-'16 time
8 period, were you surprised? Were you and your
9 colleagues surprised that heroin overdoses
10 increased?

11 Had you anticipated a decline in drug
12 overdoses as the prescribing levels dropped? Or
13 was -- was that something that did come as a shock
14 to you?

15 MS. KEARSE: Objection.

16 Q. Let me -- let me ask the question again to
17 avoid objection. You referenced a reduction in the
18 levels of opioid prescriptions in that '15-'16 time
19 period. Correct, Doctor Gupta?

20 A. Yes.

21 Q. When you saw the reduction in opioid
22 prescriptions in that time period, were you
23 surprised that heroin overdoses increased?

24 A. So we know again that opioid prescribing

1 was primarily, across the nation - and certainly
2 across West Virginia - was being done by primary
3 care physicians like myself, not addiction
4 psychiatrists, by the way, not neurobiologists, but
5 primary care physicians.

6 And we also knew that to change
7 behavior, it's going to make -- take a lot of
8 effort for -- to change the behavior of those
9 primary care physicians. But we also knew that we
10 may or may not be able to see immediate gains of
11 that.

12 And what happens with a basic tenet of
13 public health, that A plus B does not always equal
14 to C. We do not always have one-to-one cause.

15 You're always working with
16 associations in mind. That's what epidemiology is,
17 what epibiostats is. That's what public health is.
18 So you're never surprised.

19 We're not surprised at the HIV
20 outbreak that was happening because heroin use has
21 increased. So what we wanted to do in public
22 health, as a public health expert, was to -- first
23 and foremost, we have to turn off the spigot
24 somewhere, and turning off the spigot meant

1 starting to make progress and reduction in the
2 overwhelming volume of prescription opioids that
3 was flooding out communities.

4 Now, what's the consequence? We knew
5 it was not going to be a straight line. Whether
6 people who are once suffering from substance use
7 disorder will go on to the next as a transition
8 because they can't get away from their addiction or
9 their -- not enough ability for the system to
10 accommodate that level of addiction? We knew that.

11 So when we saw the transition to
12 heroin and then fentanyl, it's not a matter of
13 surprise; it's a matter of: This was the next wave
14 that was oncoming, and we have to figure out how to
15 address that.

16 So you know, we don't get surprised in
17 public health. What we do is: We're always
18 working to address the root causes of the problem
19 and then manage the consequences of the actions,
20 and that's what we've been doing since that time.

21 Q. Let me ask this way. That's -- that's a
22 very good explanation. When you reduced levels of
23 opioid prescriptions in this 2015-2016 time period,
24 I take it you didn't predict that one of the

1 results would be an increase in heroin overdoses.

2 Correct?

3 A. When you have a high level of addiction in
4 society because of prescription opioids, it's
5 almost a foreseeable consequence that things will
6 evolve. So while I can't guarantee you it was
7 going to be heroin or just fentanyl or meth, it was
8 very clear that we're going to have to deal with
9 this consequence for decades to come in the future.

10 So the way I would answer is that this
11 was pretty foreseeable when we were addressing it.
12 But that didn't mean that we would not act to
13 reduce the volume.

14 Q. What was foreseeable by you --

15 A. That --

16 Q. -- in 2015-2016?

17 A. That we had a higher level of people who
18 were suffering from substance use disorder, and we
19 have to make sure that as we're reducing the volume
20 of prescriptions, we have to figure out to make
21 sure that they're getting the help they need.

22 But in our communities, you know, we
23 didn't have the -- have the aspect of the health
24 that we needed at the time in terms of treatment,

1 in terms of reduction in stigma, in terms of
2 prevention of HIV outbreaks and other things.

3 And we began to see people
4 transitioning off to the cheaper alternatives. We
5 just didn't know which alternative at the time.
6 But it was foreseeable that --

7 You know, when you have somebody with
8 -- suffering from substance use disorder or
9 addiction, you know, what do you expect? It's the
10 same thing. I mean, if you, you know, put a fire
11 in a house full of, you know, liquid oxygen, what
12 do you expect? It's gonna blow up eventually.

13 And that's kind of what's happened to
14 our community.

15 Q. As the State Commissioner of Health at the
16 time, did you take any action to avoid what was
17 foreseeable in your view?

18 A. Yes. So we began to ask more screenings
19 for communicable diseases in juvenile centers,
20 correction centers, treatment centers, other
21 places, local health departments. We increased
22 surveillance efforts; we increased vaccination
23 efforts for Hepatitis, as an example.

24 So we enhanced every aspect, because

1 we knew that once this was starting to happen,
2 consequences will happen.

3 We also, at the time, worked closely
4 in - I would say - 2017-2018 with federal DEA as
5 well as the law enforcement officials to make sure
6 when the crackdown was to happen, that my office
7 would be involved ahead of time.

8 So one of the things we did was: We
9 were the -- only the third state in the nation
10 behind the state of Washington and Maryland to
11 create protocols to engage with federal law
12 enforcement prior to a crackdown on a pain pill --
13 pain clinic, pill mill.

14 The reason that was important was:
15 They describe when a clinic gets shut down, let's
16 say there's 800 patients, nobody in the community -
17 no other physician - will take them, because nobody
18 wants to be labeled as taking patients of Doctor X.

19 Now, on one hand, I was the secretary
20 of the Board of Medicine that was actually, you
21 know, working through a disciplinary process for
22 that Doctor X and also realizing that nobody else
23 was gonna step up because they're afraid of their
24 license being in trouble.

1 So we created protocols where via
2 doctor letters would go to in that area or that
3 county before a pill mill was about to be shut down
4 around that time.

5 We created educational resources. We
6 created all of these protocols. So we were working
7 closely with federal, state and local law
8 enforcement behind the scenes so that when that
9 action took place, you didn't just see police
10 officers and people being taken to jail, like bad
11 doctors and their staff.

12 But then we worked behind the scenes
13 to make sure those people would have resources to
14 go to so they don't end up being on the street and
15 using IV heroin. They don't end up flooding the
16 emergency room or they don't end up, worse enough,
17 dying.

18 So those are the actions that we took.

19 Q. I'm going to ask you to move to Statement
20 20. Statement 20 reads, "Chemically speaking,
21 synthetic opioids, semi-synthetic opioids and the
22 prescription opioids work through the same
23 receptors and feed the same need to the body." Do
24 you agree with that statement?

1 A. Yes.

2 Q. You're not an expert in addiction sciences,
3 you've already said, though, correct?

4 A. I'm not an addiction psychiatrist.

5 Q. Have you done any research on the effects
6 of various opioid substances on the brain?

7 A. I've not conducted any lab research on the
8 effects of opioids on the brain.

9 Q. Let's go backwards to Statement 12.
10 Statement 12 reads, "The increase in overdose
11 deaths in West Virginia during that time was caused
12 by the large volume of opioid pills that were
13 originally deposited or delivered to West
14 Virginia."

15 Do you agree with this statement?

16 A. That is my opinion.

17 Q. What is the time period that you would
18 agree that this statement is true?

19 A. I would say at the beginning of 2000-2001
20 to date.

21 Q. Now, you don't mean by the statement that
22 prescription opioids were the sole cause of the
23 increase in opioid deaths, do you?

24 A. Could you repeat that, please?

1 Q. Sure. You don't mean by this statement
2 that prescription opioids were the sole cause of
3 the increase in opioid deaths, do you?

4 A. If I heard you correctly, you said, "the
5 prescription opioids were the sole cause of opioid
6 overdose deaths." Is that what you're asking me?

7 Q. I'm asking you whether you think that
8 prescription opioids were the sole cause of the
9 increase in opioid deaths.

10 A. Prescription opioids were a substantial
11 factor in the significant rise in overdose, drug
12 overdose, deaths in West Virginia.

13 Q. Now, was the criminal distribution of
14 heroin a cause?

15 A. Heroin certainly -- heroin cut with
16 fentanyl was also a cause. But just to remember,
17 that was driven from prescription drugs,
18 prescription opioids, transitioning.

19 Q. What are some of the other causes?

20 A. So there's often not a one-to-one
21 relationship. What that means is, what we were
22 finding, that an average decedent had anywhere
23 between three and five substances in their body.

24 What would they be? They could be

1 prescription opioids; they could be benzos; they
2 could be fentanyl or heroin. So those were some of
3 the substances in that time frame of, you know,
4 2015-'16. And then we began to see meth as well.

5 Q. Now, besides just the drugs, were there any
6 causes that you studied in your role as State
7 Health Commissioner? For example, a propensity to
8 addiction?

9 A. So the Office of the Chief Medical Examiner
10 which I oversaw is a centralized medical examiner's
11 office in the state which sees all of the deaths
12 that happen from -- you know, within that statute
13 that's required. So the drug overdose deaths are
14 one part of it. So we're talking homicides, we're
15 talking other aspects of deaths.

16 So there were other deaths also that
17 happened that we track and follow.

18 Q. Did you look at the propensity for someone
19 to be addicted?

20 A. Are you speaking about the 1.8 million
21 people in West Virginia, to look at their
22 propensity?

23 Q. Well, just generally the propensity of
24 someone to have an addiction. Did you look at

1 those types of issues, other than whatever drugs
2 were in their body?

3 A. We just follow science, and in science, so
4 far we know is that you're not able to predict but
5 you know that -- you know that if someone is
6 prescribed opioids for beyond five or seven days,
7 the likelihood of suffering from substance use
8 disorder is much higher.

9 So we know that. In terms if you're
10 asking, are we doing studies with genetics or other
11 aspects? Not at the Bureau of Public Health.

12 Q. Coming back to the issue we were discussing
13 before, you know, what you were anticipating after
14 prescription opioids -- prescriptions for opioids
15 was decreased, do you remember noting somewhere
16 publicly or telling anybody publicly that you
17 anticipated that there would be consequences such
18 as an increase in heroin overdoses or anything of
19 that sort?

20 A. I mean, you would have to search my public
21 record. Clearly, we were not the only state in the
22 union. There were other states that similar
23 patterns were happening and we were recognizing
24 that. And we were anticipating that this would

1 happen because it was happening other places.

2 So this was a trend that was happening
3 across the country, not solely and exclusively in
4 West Virginia.

5 So it would be reasonable at that time
6 to form an opinion based on the findings of my
7 colleagues across the country.

8 Q. Let me switch over to Statement No. 17,
9 Doctor Gupta. Statement 17 are -- is "NAS babies
10 are a causative issue in terms of the opioid
11 epidemic." Do you agree with that statement?

12 A. I actually don't understand that statement
13 very well, so if you -- I mean, I can say my
14 opinion is that --

15 Q. Well, let me interrupt you, because our
16 time is getting short and I apologize.

17 A. Yeah.

18 Q. But I'm just asking you right now whether
19 Statement 17 is a statement you agree or don't
20 agree with.

21 A. I would generally agree broadly.

22 Q. Okay. Broadly. So does this statement
23 mean that the incidence of NAS, that neonatal
24 abstinence syndrome has increased as more opioids

1 were prescribed?

2 A. Yes.

3 Q. So that's a matter of fact, not opinion.
4 Right?

5 A. That's both a fact and an opinion.

6 Q. Well, it can be empirically proven,
7 correct, whether it's true or not true?

8 A. It can be proven, and it also goes along
9 with my experience as a physician and having to
10 visit the neonatal ICUs across the state of West
11 Virginia and neonatal ICUs across the country that
12 I see that.

13 Q. And other than what you saw anecdotally
14 across the country and across West Virginia, was
15 there some sort of systemic research or information
16 compilation that was done by your department on
17 this issue?

18 A. Absolutely.

19 Q. What was that?

20 A. We, first of all, created a clinical
21 definition for NAS that we had all the birthing
22 facilities in the state of West Virginia, including
23 Cabell County and City of Huntington's hospitals
24 agree to.

1 And all of the doctors - meaning the
2 birthing physicians in Cabell County and all across
3 West -- across West Virginia, agreed to a common
4 definition. Once we did that, we then started to
5 capture that definition and those diagnoses in a
6 program called Birth Score out of West Virginia
7 University.

8 We worked very closely with experts in
9 Marshall, at Marshall University, to measure the
10 amount of NAS that was happening. And I'm using
11 NAS intermittently with NOWS, which is neonatal
12 opioid withdrawal syndrome, and we then
13 characterized the rate of NAS per county, and we
14 found that the average rate of NAS in the state was
15 5 percent. That's 1 in 20 babies, which is the
16 highest by far of any state in the nation.

17 But we also found that some of the
18 counties had much higher rate, to the tune of 10
19 and over 10 percent. Again, that's a published
20 report, available in the public domain. And I -- I
21 don't have a -- you know, a lot of recollection
22 about every aspect of it.

23 Q. Do you remember who within your
24 organization primarily did the research for that

1 report?

2 A. It would have been the -- under my
3 supervision, the Department of Family and
4 Children's Services.

5 Q. Statement 21. Let's turn to that for a
6 moment. "Children diagnosed with at birth have
7 noticeable difficulties learning and paying
8 attention." Do you agree with that statement?

9 A. Once again, diagnosed with NAS is what's
10 missing here, but if we could put "with" blank,
11 because that's just -- it's an error in the
12 statement.

13 Q. Okay.

14 A. So -- yeah.

15 Q. So with that "NAS" added, do you agree with
16 that statement?

17 A. Yes.

18 Q. Now, you don't have any training in
19 neonatology or pediatrics, correct?

20 A. Actually, I have had rotations during my
21 training in pediatrics and neonatology.

22 Q. When you were a resident; is that correct?

23 A. When I was in medical school, and I don't
24 remember if it was residency too. But I've also

1 done emergency room coverage that included -- as
2 well as my primary care practice, that included
3 children.

4 Q. Okay. And that includes neonatology as
5 well?

6 A. I have not taken care of NICU babies, so
7 no.

8 Q. Have you done any research on the incidence
9 of attention or learning deficits in children
10 diagnosed with NAS?

11 A. Not personally, I have not.

12 Q. Do you know what percentage of children
13 diagnosed with NAS exhibit noticeable difficulties
14 learning and paying attention?

15 A. We are just at the precipice and that data
16 is evolving, so I can't tell you for certain what
17 that percent is.

18 (Background noise.)

19 MS. MAINIGI: If someone is off mute,
20 could you please go on mute? I hear some
21 background or interference. Is there a --

22 MS. KEARSE: Someone needs to be put
23 on mute.

24 (A discussion was had off the record

1 after which the proceedings continued
2 as follows:)

3 BY MS. MAINIGI:

4 Q. Doctor Gupta, do you have any studies or
5 reports that would support the statement in 21 that
6 you --

7 A. Yes.

8 Q. -- can give me?

9 A. Yes.

10 Q. What are they?

11 A. There's a number of reports, including --
12 if you go to the CDC website, and that clearly
13 talks about some of the challenges in learning as
14 well as memory development, cognitive development
15 as a consequence of NAS.

16 Q. Now, can you tell me what percentage of NAS
17 diagnoses result from prescription opioid use
18 versus illicit opioid use?

19 A. Once again, very similar to people who die
20 and you cannot tell in them because the metabolites
21 are the same. To the developing baby, it doesn't
22 really matter whether it's prescription or
23 otherwise, so --

24 What I can tell you is: We did

1 studies in West Virginia at Bureau of Public Health
2 and we found that one out of five babies' cord
3 blood had a substance positive. That was with --
4 that was inclusive of prescription as well as
5 illicit.

6 We also found that almost 15 percent
7 of intrauterine exposure was positive for
8 substances. And I believe that was prescriptions.

9 But once again, I don't have access to
10 that data right now, so I cannot be 100 percent
11 certain at this point.

12 Q. The one-out-of-five statistic, was that
13 something that was published by --

14 A. Yes.

15 Q. -- by who?

16 A. We have published that. So the first study
17 was published by -- by one of the neonatologists -
18 we funded the study at CAMC - Doctor Stefan
19 Maxwell.

20 Q. 22, "As children with NAS enter the
21 classroom, there will be noticeable, interruptive
22 and impulsive behavioral issues." Do you agree
23 with that statement?

24 A. Yes.

1 Q. Are you making that statement as a mental
2 health professional?

3 A. I'm making that statement as a Commissioner
4 who has interacted with hundreds of teachers,
5 school board members and parents and has learned a
6 lot through interacting with actual West Virginians
7 on the ground.

8 It is my opinion with a reasonable
9 degree of certainty that children, as they're
10 growing up who are diagnosed initially with
11 neonatal abstinence syndrome have a significant
12 difficulty oftentimes with impulse control, with
13 focus in classroom issues and may sometimes get
14 misdiagnosed as ADD.

15 Q. Do you -- besides your own experience
16 talking to teachers and so forth, do you have any
17 studies that you can cite to?

18 A. Yes. So there's a lot of literature. I'm
19 happy to share with you. Some of the folks that
20 have worked on this is people like Stephen Patrick
21 at Vanderbilt and others. That literature is there
22 and is evolving and includes - which is not
23 mentioned here - some of the birth defects as well
24 of children with NAS.

1 Q. Okay. And let's go back to No. 8. No. 8
2 reads, "The opioid epidemic has lead to an increase
3 in the number of children entering the foster care
4 system, rapidly increasing child welfare costs to
5 the state." Do you agree with that statement?

6 A. Yes.

7 Q. Now, the foster care system in West
8 Virginia was the responsibility of a different part
9 of DHHR than your office; is that correct?

10 A. That's correct.

11 Q. You did not oversee the foster care system,
12 did you?

13 A. I did not.

14 Q. Where did -- what's your basis for this
15 statement then?

16 A. In addition to being the Commissioner of
17 the Bureau for Public Health, as I mentioned
18 before, I'm also -- I was also the State Health
19 Officer. That being, it was my responsibility in
20 that role to be overseeing the -- you know, number
21 of other aspects of the public health system.

22 So we interacted frequently with and
23 worked closely with -- with the -- that particular
24 department, as well as our parent department, which

1 is the Department of Health and Human Resources, as
2 I -- and I reported to my boss, which is the
3 Cabinet Secretary.

4 Now, clearly I was open to looking at
5 the data for the foster care system, and saw and
6 experienced in our budget presentations to the
7 legislature each year that we worked together with
8 the commissioners who create that, and we reported
9 on this.

10 The Cabinet Secretary is on the record
11 stating in his testimony - where I was present -
12 that about 90 percent of the cost of foster system
13 in West Virginia is associated in some form or
14 other with the opioid crisis or the substance use
15 disorder crisis.

16 So that's something that is on the
17 record from my boss, and of course, it's my opinion
18 based on that and some of the budgetary and other
19 factors and working closely with the -- my
20 co-agency, that this statement holds true with a
21 substantial -- and again, a reasonable degree of
22 certainty.

23 Q. So opioid prescription medications require
24 a prescription; is that correct?

1 A. Not always. As we discussed, that people
2 do not need to have a prescription in order to have
3 access to prescription opioids when -- especially
4 when the volume in a community is overwhelming.

5 Q. Well, to legally obtain prescription
6 opioids, you need a prescription, correct?

7 A. Correct.

8 Q. Okay. You can't buy them over the counter,
9 correct?

10 A. Correct.

11 Q. And the prescription must be written by a
12 health care provider who is licensed by the State
13 and registered with the DEA, correct?

14 A. Correct.

15 Q. And it must be dispensed by a pharmacist
16 who's also licensed by the State and registered
17 with the DEA, correct?

18 A. Correct.

19 Q. And no prescription opioid can leave a
20 pharmacy lawfully unless a doctor decides to
21 prescribe the prescription and a pharmacist decides
22 to dispense the prescription, correct?

23 A. Incorrect.

24 Q. And why is that?

1 A. Because doctor is not the only prescriber.
2 You could have other prescribers as well.

3 Q. Fair enough. So let me ask it again then.
4 So a prescription opioid cannot lawfully leave a
5 pharmacy unless a doctor or other qualified
6 prescriber decides to prescribe the prescription
7 and the pharmacist decides to dispense the
8 prescription. Correct?

9 A. Correct.

10 Q. Your Statement No. 2, let's go to that for
11 a moment, please. "The amount of appropriate
12 prescriptions was dwarfed by the amount of
13 inappropriate prescriptions that were being
14 diverted." Is that a statement you agree with?

15 A. Yes.

16 Q. What do you mean by the term "inappropriate
17 prescription"?

18 A. Prescriptions could be - as I mentioned
19 here, or you can see here - is appropriate
20 prescription. That means there are criteria in
21 which it might make sense to prescribe opioids. In
22 other situations, it may not make sense to
23 prescribe opioids, and in those situations, you
24 know, we would call that inappropriate prescribing.

1 So getting 30 days of Vicodin for a
2 tooth pull would be an example of inappropriate
3 prescribing. Seeing 100 patients in a day without
4 doing appropriate background, looking at patients,
5 understanding their history, doing a physical exam,
6 is another example of what we consider pill mill or
7 inappropriate prescribing in a large volume.

8 So these are some of the -- you know,
9 dentists, others that -- you know, I said,
10 cataract, an ophthalmologist prescribing 30 days of
11 prescription, is an inappropriate example.

12 So that's my -- but someone who has --
13 is -- has terminal cancer and has exhausted any
14 other options, is on opioids, well controlled, is
15 an example of appropriate prescribing for opioids.

16 So that's my description between
17 "appropriate prescription" and "inappropriate
18 prescriptions."

19 Q. You're not an expert in pain management,
20 correct?

21 A. I have served on some panels in terms of
22 the West Virginia SEMP panel and others. I have
23 provided training and talks to the State-level
24 conferences. But I have not received any formal

1 training on pain management beyond my residency
2 training and beyond my ex -- sort of expertise of
3 25 years of managing private care physicians,
4 primarily where we were the ones that were --
5 became the target of writing these prescriptions.

6 So that would be my answer.

7 Q. Your definition of "inappropriate", as I
8 heard it, Doctor Gupta, may include prescriptions
9 that were written legally, correct?

10 A. Correct.

11 Q. And it could include, in fact, millions of
12 prescriptions that were written legally, correct?

13 A. Sure.

14 Q. And your definition of "inappropriate" may
15 also include prescriptions that were within the
16 standard of care that existed at the time they were
17 written, correct?

18 A. They may or may not be.

19 Q. Give me an example of a prescription that
20 you would call "inappropriate" but that was written
21 within the standard of care for the time.

22 A. So the standard of care did not require --
23 strike that.

24 We had ample evidence to demonstrate,

1 through studies, that opioids do not help control
2 or improve function in chronic pain, yet millions
3 of prescriptions were being written for chronic
4 pain for opioids. That's an example.

5 Q. And at some point in time, at least,
6 prescribing opioids for chronic pain was within the
7 standard of care, correct?

8 A. One can argue that, but the fact of the
9 matter is that opioids as a first line of therapy
10 for chronic pain were never standard of care.

11 So prescribing opioids in high volume,
12 in high doses, high strength, as a first line for
13 chronic pain, without any other alternatives, I
14 don't understand to be the standard of care.

15 Q. And so what did West Virginia do about that
16 through the Board of Pharmacy, the Board of
17 Medicine or any other institution within the
18 state of West Virginia?

19 A. Clearly, as I mentioned - I'll go from --
20 you know, from now to backwards - when the 2016 CDC
21 guidelines came out in March of 2016, we assembled
22 a panel at the Department of Health and Human
23 Resources. We brought together all the experts,
24 including insurers, exec -- you know,

1 representative prescribers and others, and we
2 adopted the guidelines and encouraged that. That's
3 one action.

4 Second, we created the SEMP panel pain
5 -- prescribing pain guidelines which I was a part
6 of. That's another one.

7 We also made sure that there was
8 appropriate trainings that were happening - which I
9 mentioned I spoke at oftentimes - the appropriate
10 prescribing, that was the third one.

11 The Board of Medicine worked to
12 develop a wide guidance to physicians on
13 appropriate prescribing.

14 Those are some of the things that I
15 can remember. And then, of course, the legislature
16 at the same time created the Opioid Reduction Act.

17 The legislature also mandated
18 requirement of three hours of CME at every cycle of
19 renewal of license for all prescribers related to
20 training of appropriate prescribing for pain
21 medications.

22 Q. Doctor Gupta, why didn't you or the State
23 of Virginia -- excuse me, the State of West
24 Virginia, act prior to the 2016 time period?

1 A. Could you please repeat the question?

2 Q. Sure. It was poorly worded. Why didn't
3 you or the State of West Virginia act prior to the
4 2016 time period --

5 A. But we --

6 Q. -- to reduce the number of inappropriate
7 prescriptions?

8 A. So the opioid prescribing, the CME
9 requirement, I believe was actually before 2016.

10 Q. When do you think that was?

11 A. I don't remember exactly, but it was prior
12 to 2016. Governor Tomblin put up a Governor's
13 Advisory Committee on Substance Abuse, GACSA. That
14 was also prior to 2016.

15 There were a number of things,
16 including -- inclusive of these. The Board of
17 Medicine promulgated some opioid prescribing
18 guidelines that were also prior to 2016.

19 So I think it's -- it's not
20 appropriate to characterize that West Virginia did
21 not do anything prior to 2016. It did.

22 Q. Did you do anything prior to 2016 to
23 address the problem of inappropriate prescriptions?

24 A. I mentioned a lot. I'm happy to go back

1 and restate all the things that I had done before
2 that, which is: In 2015, January, when I came into
3 the office, we clearly began to work to advise and
4 educate physicians across the state in both
5 appropriate prescribing, worked to develop the
6 educational seminars and support the educational
7 activities of prescribers across the state.

8 Worked my -- worked with my colleagues
9 to conduct the assessments as well as continue to
10 help fund looking at the NAS issue, to move to
11 develop a clinical definition, to get that adopted
12 by all prescribers in all the birthing facilities.

13 Worked with OB-GYNs across the state
14 to ensure there was universal screening happening
15 for our pregnant people for substance use disorder,
16 and then they would be connected to treatment.

17 Working with Board of Pharmacy to make
18 sure that they were doing everything possible that
19 they could to reduce and impact positively.

20 Worked with law enforcement. You
21 know, so we were providing -- so there's a lot of
22 activities that happened between 2015 when I joined
23 in November of 2018. But specifically also the
24 ones I stated between 2015 and '16.

1 Q. Why were actions not taken as early as
2 2006, '07, '08, '09 in the state of West Virginia
3 to reduce the writing of inappropriate
4 prescriptions?

5 A. You would have to ask somebody other than
6 me, because I wasn't the Health Commissioner then.

7 MS. MAINIGI: Why don't we take a very
8 short break. I just want to quickly look at my
9 notes to see if I have any stray questions left for
10 you, Doctor Gupta, and I just need like three, four
11 minutes.

12 MR. COLANTONIO: We were -- we're
13 supposed to be over at 4:10. Just saying.

14 MS. KEARSE: Okay. So why don't we --
15 okay. We may just have some clarifying things.
16 Want to go ahead and take ten or --

17 MS. MAINIGI: If you would like to
18 take ten, I don't -- I need to just check my notes,
19 Anne, to see if I have any stray questions.

20 MR. COLANTONIO: Take five. Take five
21 maybe?

22 MS. MAINIGI: That's fine. That's --
23 let's take five.

24 VIDEO OPERATOR: Going off the record.

1 The time is 4:05 p.m.

2 (A recess was taken after which the
3 proceedings continued as follows:)

4 VIDEO OPERATOR: Now begins Media Unit
5 4 in the deposition of Rahul Gupta, M.D. We're
6 back on the record. The time is 4:17 p.m.

7 BY MS. MAINIGI:

8 Q. Doctor Gupta, before the break, we were
9 talking about the concept of inappropriate
10 prescribing, and I wanted to ask you about the
11 following scenario. So for an acute pain event
12 like getting your wisdom teeth pulled or knee
13 surgery or something like that, you would agree
14 that getting a prescription for opioids is a
15 legitimate prescription and legitimate use.
16 Correct?

17 A. Not all the time.

18 Q. Well, let me -- let me ask you to separate
19 the number from the legitimacy of a prescription to
20 begin with. As I understand your testimony today,
21 what you see as inappropriate is in the case of
22 knee surgery, for example, providing 50 pills when
23 five may be all that are medically necessary. Is
24 that fair?

1 A. That would be -- for knee surgery, the
2 exact example you provided, makes sense.

3 Q. But in the case of knee surgery -- let's
4 use knee surgery as our example. You agree that
5 with knee surgery, five at least - maybe a few more
6 - opioid pills would be reasonable. Correct?

7 A. Well, the -- the point is that there may be
8 some people who do not need that opioid pill. So
9 if we start going around writing everybody who gets
10 it automatically a prescription for whatever and
11 dose for whatever and the strength for whatever, is
12 the exact mess we're in, in the first place.

13 Q. And so --

14 A. That's the problem.

15 Q. Sorry. There are -- in your view, there
16 might be a patient who is having a minimal amount
17 of pain with a knee surgery and could be fine with
18 just Advil. Is that fair?

19 A. That's very accurate. And the same thing
20 goes for the majority of dental extractions, for
21 example, do not need 30 days of opioids. But
22 that's not the case that was happening.

23 Q. And the person who's in the best position
24 to judge whether that person needs five or 20 pills

1 of opioids or could get by with Advil would be the
2 prescriber. Correct?

3 A. Correct.

4 MS. MAINIGI: I have no further
5 questions right now. All I will say is: To the
6 extent that there are any clarifying questions that
7 are asked of Doctor Gupta now, I reserve the right
8 to obviously have equal time for follow-up on that.

9 MS. KEARSE: Sure.

10 EXAMINATION

11 BY MS. KEARSE:

12 Q. Doctor Gupta, I'm going to be very quick.
13 I just want to clarify basically two points from
14 the testimony we did today and our drafting of the
15 bullet points that I think we've discussed earlier
16 that we tried to summarize from your testimony with
17 that. So there's two clarifications I want to make
18 sure that we have it right and we're clear on what
19 your actual opinion is.

20 I want to first start with Bullet
21 Point No. 1, and this was Exhibit No. -- what was
22 the exhibit number? 58. And this is one where we
23 said that the opiate prescription drugs, their
24 volume and their consequential addiction and other

1 diseases, it says "OUD rose by thousands of percent
2 over a decade." And I want to show you just what I
3 was -- what I think where we looked in the
4 transcript, and maybe we can clarify whether it's
5 thousands or, you know, substantial.

6 But you were asked some questions
7 about addiction, and this is on page 324, and you
8 were -- and I don't know if you'll recall this, and
9 this is just a very quick just section of your
10 transcript.

11 But you were talking about that
12 alcohol challenges did not rise by a thousand of
13 percent when you were asked about alcohol and you
14 were trying to -- you were testifying to the extent
15 if it's different with the opioid with that too,
16 and with the opiate prescription drugs and volumes
17 that did rise, it's followed by the thousands.

18 If you'll just read that and maybe we
19 can just clarify whether it's thousands or a
20 substantial rise on that. We can look at --

21 MS. MAINIGI: Objection to form.

22 Q. Okay. So let me ask you this -- if you'll
23 read -- we cited in the disclosure to the actual
24 page number, and on page 324 and 325, we -- you

1 testified that to now take that out "wouldn't be
2 fair because alcohol -- alcoholism and alcohol
3 challenge did not rise by thousands of percent over
4 a decade. Opiate prescription drugs and volume"
5 did rise.

6 So let me say if we took out
7 "thousands," and maybe that's where you're not
8 comfortable. And I can ask you that question.
9 What in Bullet Point No. 1 are you not comfortable
10 with in regards to your opinion?

11 MR. HESTER: Objection to form.

12 MS. MAINIGI: Objection to form.
13 Objection, Ms. Kearse, to you testifying and trying
14 to put words in the mouth of this witness. This
15 witness has already testified that he did not
16 object -- that he did not agree with this
17 statement, Statement No. 1.

18 MS. KEARSE: And I can ask him what is
19 it he does not agree with?

20 A. Yes, so the -- my deposition of September
21 2020 very accurately describes what I meant to say.
22 And I'll say that again for the record. What I
23 said was that the opioid prescription drugs and the
24 volume of prescribing has risen by thousands of

1 percent over a decade. And I stand by that.

2 Q. Okay, Doctor. And that -- that would
3 reflect -- is there anything else in No. 1 that you
4 -- that you have issue with, the addiction and
5 others associated with OUD rose as well?

6 MS. MAINIGI: Objection to form.

7 A. I'd have to read it again.

8 Q. Okay.

9 A. So you know, again, in public health
10 epidemiology, if -- you know, just because a
11 thousand people take a bad batch of drugs doesn't
12 mean everybody dies. A few people will die, a few
13 will be really, really sick. I mean, we can use
14 the pandemic right now as an example. Not
15 everybody who gets the infection from COVID dies or
16 ends up in a hospital.

17 Some people will be fine. Others will
18 end up in a hospital. Some will end up on a
19 ventilator, and others will die. Just like that.

20 When a prescription volume increases
21 by thousands of percent, then obviously there will
22 be a proportional increase in OUD. That doesn't
23 necessarily have to be thousands of percent. But
24 people suffering from it would clearly be way more

1 than there would have been otherwise if we didn't
2 have thousands of percent of increase in the
3 prescription -- the volume of drugs out there for
4 opioids.

5 That's what I meant, and that's what
6 I'd like to make sure that is reflected in No. 1.

7 Q. Great. Thank you, Doctor. And I believe
8 on No. 4, there was another -- again, with --
9 where's No. 4? Bullet Point No. 4, basically
10 talking about the -- once the addiction is formed,
11 and I want you to -- maybe we can explain
12 specifically - I don't need the transcript up there
13 - when someone is addicted to prescription pills,
14 do they sometimes then abuse drugs?

15 MS. MAINIGI: Object to form.

16 MR. HESTER: Object to form.

17 A. So when someone develops a substance use
18 disorder or addiction, what basically would happen
19 is that they're no longer themselves physically in
20 control of the addiction. By the time they take a
21 pill or any other way of taking that substance,
22 they will get a high in terms of a release of
23 Dopamine.

24 After a while, you need certain

1 Dopamine just to keep you away from withdrawal and
2 to prevent that. And it isn't high as much as it
3 is the need to continue to, you know, feed -- feed
4 the need for elevated levels of Dopamine.

5 Now, when that happens and you take
6 the substance away from a person in terms of they
7 don't have the opioid pills anymore, that person
8 starts to look for other ways to substitute that
9 need.

10 Now, that person could go on on the
11 street and purchase heroin; they could do that. If
12 they are doing it and they run out of money - and
13 oftentimes people, you know, may lose their job
14 because of the habit, because of the addiction, may
15 lose their family, may lose their health, may be
16 cut off from the community - so what do they do at
17 that time when they're suffering?

18 Not everybody, but some people. Well,
19 they have to find other means to continue to feed
20 the need of the disease. And therefore people may
21 conduct activities -- you know, their inner brain
22 again, which is in control, is telling the frontal
23 lobe and the rest of their brain: Do whatever it
24 takes to get the substance.

1 So in that sense, they're held hostage
2 to the need to have Dopamine. And people will
3 sometimes take on activities that may not be legal,
4 and they may not be fully aware of that either.

5 So that's where we end up seeing
6 people -- again, anything from purchasing heroin
7 off the street to other activities that they may be
8 conducting, including prostitution, you know, petty
9 theft, other crimes, in order to get the --
10 whatever the money that's needed to fulfill that
11 habit, that disease -- to fulfill that.

12 And that's kind of what I -- what I
13 would explain it by.

14 Q. Okay, Doctor, I think that clarifies it.
15 You're prepared to testify and explain what can
16 happen when a person forms an addiction. Correct?

17 MS. MAINIGI: Objection to form.

18 MR. HESTER: Object -- yeah, objection
19 to form.

20 A. Yes.

21 Q. Okay.

22 MS. KEARSE: I have no further
23 questions unless anyone else on the plaintiff's
24 side has any questions.

1 MR. FARRELL: Yeah, this is Paul
2 Farrell. I have a couple follow-up questions.

3 EXAMINATION

4 BY MR. FARRELL:

5 Q. Doctor Gupta, in your role as the State
6 Health Officer in West Virginia, have you ever
7 undertaken the task to estimate the economic cost
8 of the opioid epidemic on -- on our state?

9 A. Yes.

10 MS. MAINIGI: Objection to form.

11 A. Yes. We -- soon after the White House
12 Council of Economic Advisors report came out, I
13 believe in 2017, that showed almost half a trillion
14 dollars cost to the country of the consequences of
15 the crisis, we actually looked at -- and there was
16 some work that was done by Alex Brill - I think
17 it's the American Enterprise Institute - and we
18 took that data and we looked at the West Virginia
19 numbers and we found approximately 12 and a half
20 percent of West Virginia's GDP was being lost each
21 year because of the crisis.

22 MS. MAINIGI: Objection, move to
23 strike that entire answer and the question as well,
24 as outside the scope of this deposition and outside

1 the scope of Exhibit 58.

2 MR. FARRELL: No further questions.

3 Thank you, Doctor.

4 MS. MAINIGI: Doctor Gupta, I have
5 some follow-up, please.

6 RE-EXAMINATION

7 BY MS. MAINIGI:

8 Q. Let's go back to some of the language that
9 you used earlier. You referenced -- you looked at
10 some deposition testimony of yours, and you
11 referenced a thousands of percentage increase over
12 a decade. Do you recall that just a few minutes
13 ago?

14 A. Yes.

15 Q. Can you define the decade for me?

16 A. Anywhere between 2001 -- 2001 to 2011-'12.

17 Q. So when you were referring in your
18 deposition testimony that Ms. Kearse then put on
19 the screen to show you again and you used the word
20 "decades," the decade that you were referring to
21 was approximately 2001 to 2012, correct?

22 A. I wasn't referring to one single decade
23 because what we're talking about in the context of
24 what we were discussing in the deposition was from

1 2001 to 2020.

2 Q. Okay. I'm asking you first to just focus
3 on your deposition testimony, and you remember
4 Ms. Kearse showed you your deposition testimony?

5 A. We can look at it -- if we could put it up
6 again, I'm happy to look at it.

7 Q. Well, Ms. Kearse I think put it up.

8 MS. MAINIGI: So Ms. Kearse, can you
9 put that testimony back up that you put up before?

10 MS. KEARSE: Page 324?

11 She's getting it.

12 MS. MAINIGI: Thank you.

13 MS. KEARSE: Just put the paragraph up
14 about thousands of percent of opiate prescription
15 drugs. 324 and 325. You need 325 on there too.
16 Go to the next -- yeah.

17 BY MS. MAINIGI:

18 Q. Okay. Do you see your statement here, "did
19 not rise by thousands of percent over a decade"?

20 A. Yes.

21 Q. Okay. Can you tell me what -- the "decade"
22 is singular there. What decade are you referring
23 to there?

24 A. Well, we're talking about alcoholism.

1 Because I'm not talking -- and at that point, when
2 I say "did not rise by thousands of percent over a
3 decade," I'm talking about alcohol and alcohol
4 challenge.

5 Q. Is that --

6 MS. MAINIGI: Ms. Kearse, I'll ask
7 you, is that what you put on the screen previously?

8 MS. KEARSE: That's -- yeah, the
9 "Opiate prescription drugs and volume of that did
10 rise".

11 Q. Okay. So the decade that you're referring
12 to here, Doctor Gupta, relates to alcoholism and
13 alcohol challenge?

14 A. Right.

15 Q. Okay.

16 MS. MAINIGI: And Ms. Kearse, you're
17 representing that that's what you put on the screen
18 previously to show Doctor Gupta when you were
19 questioning?

20 MS. KEARSE: Page 324 and 325.

21 MS. MAINIGI: Okay.

22 Q. As it relates to opioid prescription drugs,
23 Doctor Gupta, to the extent you have ever stated
24 that those have risen -- risen by thousands of

1 percentages over a decade, is it still your
2 testimony that the decade you'd be referring to is
3 2001 to 2012?

4 A. So what I just said is 2001 to 2012 is what
5 I've talked about alcohol. With opioids, I would
6 generally speak about 2001 to 2020. That includes
7 the 780,000,000 pills that was shipped into the
8 state between 2007 and 2012.

9 Q. And in terms of what you mean by "thousands
10 of percentages," what do you -- can you describe
11 what you mean by that statement?

12 A. Yeah, so I'll read that again just to make
13 sure we're on the same page. "So now to take that
14 out" -- can we go up a little bit, please? The
15 question was: "Has alcohol use disorder been a
16 long-term -- long-standing challenge in West
17 Virginia?" My answer was, "Yes, an alcohol
18 disorder within -- which I will discuss as a very
19 different challenge in many of the states, and
20 we've already talked about today earlier how there
21 will be always a level of population" that will be
22 -- have addictive behaviors. That will be
23 addictive behaviors.

24 So now to take that out wouldn't be

1 fair because alcohol -- alcoholism and alcohol
2 challenge did not rise by thousands of percent over
3 a decade." Opioid prescription drugs and volume of
4 that did rise.

5 I do not state here by what thousands
6 of percentage or what decade. I just don't say
7 that here in my testimony.

8 Q. Okay.

9 A. I'm sorry if I'm missing something.

10 Q. What do you mean as it relates to opioid
11 prescription drugs when you refer to thousands of
12 percentages? Do you have a specific range of
13 percentage in mind?

14 A. What I mean to say is the opioid
15 prescription drugs and volume rose significantly
16 from 2001 to 2020.

17 Q. Did you actually -- do you actually have a
18 specific percentage in mind? Have you done any
19 analysis?

20 A. The specific number I have in mind is the
21 780,000,000 pills dumped into the state from 2007
22 to 2012.

23 Q. And would you say that the 780,000,000
24 dumped into the state and the corresponding

1 percentage number associated with it, that those
2 are specific facts that are ascertainable?

3 A. Sure. Those are facts, but the rise from
4 2001 to 2020 with those specific 780,000,000 pills
5 additionally is my opinion, based on a substantial
6 -- a reasonable level of certainty.

7 Q. You are not an economist, correct?

8 A. I'm sorry?

9 Q. You're not an economist, correct?

10 A. I am not a practicing economist, no, ma'am,
11 I'm not.

12 Q. Thank you.

13 MS. MAINIGI: I have no further
14 questions. Anybody else from the defense side that
15 has a follow-up question for Doctor Gupta?

16 MR. HESTER: No questions from me.

17 MS. CALLAS: No questions from ABDC.

18 MS. MAINIGI: Okay, thank you for your
19 time today, Doctor Gupta.

20 MR. COLANTONIO: He'll read.

21 VIDEO OPERATOR: We are off the record
22 at 4:38 p.m., and this concludes today's testimony
23 given by Rahul Gupta, M.D. The total number of
24 media units used was four, and will be retained by

1 Veritext.

2 (Having indicated he would like to
3 read his deposition before filing,
4 further this deponent saith not.)

5

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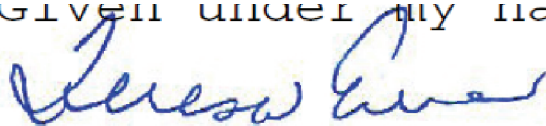
1 STATE OF WEST VIRGINIA,
2 COUNTY OF JACKSON, to wit;
3

4 I, Teresa S. Evans, a Notary Public within
5 and for the County and State aforesaid, duly
6 commissioned and qualified, do hereby certify that
7 the foregoing deposition of DR. RAHUL GUPTA was
8 duly taken by me and before me at the time and
9 place and for the purpose specified in the caption
10 hereof, the said witness having been by me first
11 duly sworn.

12 I do further certify that the said
13 deposition was correctly taken by me in shorthand
14 notes, and that the same were accurately written
15 out in full and reduced to typewriting and that the
16 witness did request to read his transcript.

17 I further certify that I am neither
18 attorney or counsel for, nor related to or employed
19 by, any of the parties to the action in which this
20 deposition is taken, and further that I am not a
21 relative or employee of any attorney or counsel
22 employed by the parties or financially interested
23 in the action and that the attached transcript
24 meets the requirements set forth within article
twenty-seven, chapter forty-seven of the West
Virginia Code.

My commission expires October 15, 2030.
GIVEN UNDER MY HAND day of April, 2021.



Teresa S. Evans
RMR, CRR, RPR, WV-CCR

1 STATE OF WEST VIRGINIA

2 COUNTY OF KANAWHA, to wit;

3 I, Teresa Evans, owner of Realtime Reporters,
4 LLC, do hereby certify that the attached deposition
5 transcript of DR. RAHUL GUPTA meets the
6 requirements set forth within article twenty-seven,
7 chapter forty-seven of the West Virginia Code to
8 the best of my ability.

9
10 Given under my hand this 19th day of April,
11 2021.

12
13
14
15 GIVEN UNDER MY HAND

16 

17 Registered Professional
18 Reporter/Certified Realtime Reporter
19
20
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Page 200

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April 20, 2021

To: Mark A. Colantonio, Esquire

Case Name: City Of Huntington v. Amerisourcebergen Drug Corporation

Veritext Reference Number: 4528369

Witness: Rahul Gupta, M.D. Deposition Date: 4/15/2021

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

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DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4528369

CASE NAME: City Of Huntington v. Amerisourcebergen Drug Corporation, et al.

DATE OF DEPOSITION: 4/15/2021

WITNESS' NAME: Rahul Gupta, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

Date

Rahul Gupta, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

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DATE OF DEPOSITION: 4/15/2021

WITNESS' NAME: Rahul Gupta, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

Date

Rahul Gupta, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

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ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 4528369

PAGE/LINE(S) / CHANGE /REASON

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Date Rahul Gupta, M.D.

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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